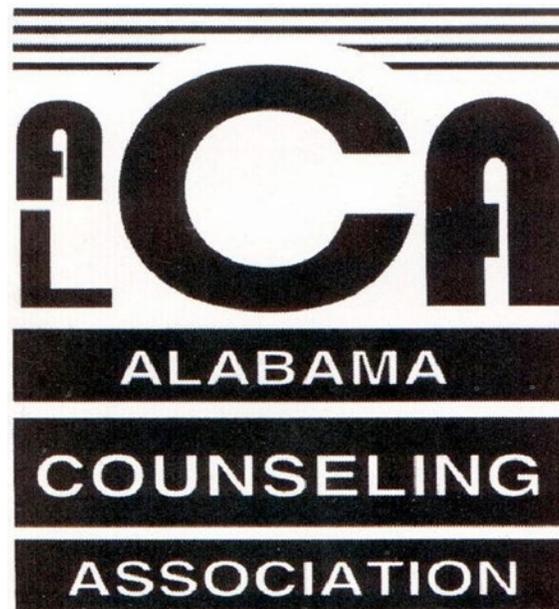# The Alabama Counseling Association Journal

- Enhancing human development through the lifespan
- Promoting public confidence and trust in the counseling profession
- Caring for self and others
- Acquiring and using knowledge
- Respecting diversity
- Empowering leadership
- Encouraging positive change

Letter from the Editor

Welcome to the Fall 2018 edition of The Alabama Counseling Association Journal. There are so many current issues impacting the counseling profession including the initiative to fund Mental Health Counseling in Schools.

President Signs Law Funding Mental Health Programs for 2019

On Sept. 28, President Donald Trump signed into law H.R. 6157, a measure to fund the Department of Health and Human Services, the Department of Education and other federal agencies for fiscal year 2019.

The bill includes funding for many important initiatives related to mental health and school counseling. Among them is a pilot program sponsored by Senators Bill Nelson (D-FL) and Marco Rubio (R-FL) to test and evaluate partnerships between universities and state and local education agencies to train school counselors and other mental health professionals for positions in public school systems serving low-income communities. ACA members and staff advocated for House and Senate approval of this new program that will help school counselors and students nationwide.

Dr. Eddie Clark

Editor

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TABLE OF CONTENTS

Bereavement Relative Loss and Greif: Implication for Counselors

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Abstract

The importance of the achievement of personal resolution following bereavement-related loss and grief is well documented in the professional bereavement literature. Personal resolution refers to the achievement of an improved state of adjustment following a death that is acceptable for each bereaved person. The variables of interest in this study were participation in individual counseling, participation in grief-support groups, perceived helpfulness of social support, and overall level of hope. This literature review addressed whether personal resolution following bereavement-related loss and grief differed based on race and differed based on the relationship to the deceased.

Lose and Grief

       Loss-related grief during bereavement is considered a universal and normal phenomenon (Altmaier, 2011; Granek, 2010; Neimeyer, 2006, 2012; Worden, 2009); yet, the pain of separation from those who are loved can be difficult to endure. According to Park and Halifax (2011), "the resolution of grief is important" (p. 356) and the ramifications of unresolved grief can be multi-faceted and experienced far into the future. The importance of personal resolution of grief, as well as predicting personal-resolution of loss-related grief, is not a new quest for bereavement reserachers. Parkes (1985) previously acknowledged the need to identify appropriate measures that will contribute to personal resolution of bereavement-related grief and that have been shown to decrease grief-related future problems. This study sought to add to the dearth of existing quantitative bereavment literature by examining personal resolution of grief following the death of loved-ones. Personal resolution is the individualized recovery from the effects of loss resulting from a major life event such as death (Burnett, Middleton, Raphael, & Martinek, 1997).

       There is a reciprocity process between love and loss-related grief represented systemically throughout the bereavement literature (Parkes, 2006, 2011; Neimeyer, 2006, 2012; Worden, 2009). Though losses incur through death and non-death related occurrences; the loss most thought of by society is the loss that occurs through the death of people we love (Humphrey, 2009). In the Centers for Disease Control and Prevention's National Vital Statistics Report (NVSR; Centers for Disease Control [CDC], 2012), it was indicated the number of deaths in the United States for 2010 and 2011 was more than two and a half million. That is, millions of deaths that translate into billions, perhaps trillions, of bereaved people from varying cultures and demographics who on some level are experiencing death-related loss and grief at any given time.

Maya Angelou (1994), author and poet, stated, "What is true anywhere is true everywhere" (p. 11). In other words, *all* people grieve in some way.   Furthermore, Worden (2009) put forth that evidence suggests that *all* humans experience grief related to loss in varying degrees, including every society and culture in every part of the world.

Though a person may experience a period of bereavement at any given time, most bereft people advance through bereavement without any residual problems (Bonnano, Wortman, & Nesse, 2004; Cutcliffe, 2004; Parkes, 2011). However, despite the normal conception of the bereavement experience in the professional literature, many persons seek assistance to manage the associated grief reactions that can have physical, emotional, cognitive, behavioral, sexual, and spiritual components, varying in length and disruptiveness (Dent, 2005; Neimeyer, 2006; Silverberg, 2007; Worden, 2009). Whether the experience of grief following bereavement is met with resilience, is uncomplicated, or is complicated; time spent grieving is a reality in people's lives. Angelou (1994) offered the perspective that life is a gift and time passed cannot be recaptured. In other words, life spent engaged in distressful loss-related grief is time living potentially devoid of the possible richness and fullness offered in the brevity of life (Brooke, 2001; Granek, 2010; Rando, 1991). In support of the widely held view endorsing timely personal resolution of grief (Granek, 2010), evidence in the bereavement literature has suggested and bereavement-researchers have suggested that there is a gap in quantitative, bereavement research literature (Bonanno & Kaltman, 1999; Currier, Neimeyer, & Berman, 2008; Jordan & Neimeyer, 2003; Parkes, 2011). Similarly, Cutcliffe (1998, 2004), a qualitative researcher of hope during bereavement, encouraged quantitative researchers to conduct studies addressing hope and personal resoluton in the bereft client.

The literature of bereavement research substantiates that bereavement can be detrimental to mental and physical health, as well as overall well-being (Bonanno & Kaltman, 2001; Granek, 2010; Neimeyer, 2006; Prigerson et al., 1997). Bonanno and Kaltman (2001) performed comparisons across bereavement studies and identified elevated depression, cognitive disorientation, and health problems that may last from several months to one to two years. In addition to the many possible negative psychological and medical symptoms resulting from bereavement, death of the bereaved is also a risk (Bonanno & Kaltman, 2001; Prigerson et al., 1997); thus reinforcing the need for research of personal resolution among those who have experienced a loss through death.

Personal resolution in the bereavement literature is referred to as grief outcome variables. Many studies in the area of bereavement describe grief outcome variables (i.e., personal resolution); however, no published studies were found that address the prediction of personal resolution following a loss through death. There is an abundance of evidence in the literature that supports an eclectic approach to the achievement of personal resolution of grief during bereavement. Many bereavement authors and researchers concur that interventions that address grief during bereavement must match the problems each individual encounter during bereavement, as well as provide consideration for personal and cultural factors (Neimeyer, 2006; Neimeyer & Sands, 2011; Parkes, 2011; Zech & Arnold, 2011).

There are three purposes of this study: a) to examine whether participation in individual counseling, participation in grief support groups, perceived level of social support, and overall level of hope influences personal resolution among people who have experienced a loss through death; b) to compare personal resolution by race/ethnicity; and c) to compare personal resolution by relationship to deceased.

Possible Consequences of Loss Due to Death

The health and medical consequences, as well as mental psychosocial morbidity, physical morbidity, and mortality, are ever growing concerns for bereavement and medical practitioners, researchers, and others who provide services to the bereaved population (Bonanno & Kaltman, 2001; Buglass, 2010; Kissane et al., 1996; Prigerson et al., 1997; Shear, 2009). For example, Prigerson et al. (1997) studied 150 widows and widowers and found that complicated grieving patients, six months post loss and longer, were at higher risk for a first diagnosis of cancer, heart disease, high blood pressure, suicide ideation, and changes in eating habits within 13 - 25 months of their loss. Additionally, Mostofsky et al. (2012) studied 1,985 heart attack survivors including 270 individuals who were bereaved due to the death of a significant person within the previous six months. Nineteen suffered a heart attack within one day of the death. The Mostofsky et al. study showed the risk for heart attack following a loss through death is 21 times higher within the first day and six times higher within the first week.

Kissane et al. (1996) offered further support for the possible disparaging effects of unresolved grief by conducting a longitudinal study. These researchers examined psychosocial morbidity in families with a sample of 115 families over a 13-month period (Kissane et al., 1996). Bonanno and Kaltman (2001) conducted an extensive review of a large number of cross-sectional and longitudinal bereavement studies and concluded there is an increased risk of mortality among the bereaved population, especially in the early months following the loss. The findings of the Bonanno and Kaltman (2001) study were consistent with the findings of Kissane et al. (1996) affirming the association between bereavement and post-loss health and medical psychosocial morbidity as well as increased mortality.

The literature distinguished bereavement and grief, though at times the two terms are used interchangeably. Bereavement is the term for the objective situation of the loss of a loved one through death (Horworth, 2011; Stroebe et al., 2008; Stroebe & Schut, 2001). Bereavement, therefore, is a life stressor that brings about grief, an emotion (Stroebe et al., 2008). "Definitions of grief in the bereavement literature uniformly adopt the inclusive view in which grief is a general term embracing many affective states" (Weiss, 2008, p. 30). Loss-related grief is also normalized throughout the bereavement and grief literature (Boelen, Keijer, van den Hout, & van den Bout, 2007; Granek, 2010; Weiss, 2008; Worden, 2009). Weiss (2008) further clarified that it is not important to know the specifics of grief. It is only necessary to know it [the grief] was caused by a loss (Weiss, 2008), such as bereavement.

The picture of *normal* grief symptomology is unique to each individual person and is based on many fluid variables including individual, cultural, and societal factors; yet commonalties are readily identified in the bereavement literature. For example, included in normal grief symptom manifestations are responses that are distressful, agonizing, upsetting, and painful. The terms uncomplicated grief and normal grief are often used interchangeably in the bereavement literature and encompass a vast range of feelings and behaviors that are common after a loss (Drenth, Herbst, & Strydom, 2010; Humphrey, 2009; Stroebe et al., 2008; Worden, 2009). For example, feelings of sadness, anger, anxiety, loneliness, fatigue, and helplessness are often reported by bereaved clients (Drenth et al., 2010; Humphrey, 2009; Stroebe et al., 2008; Worden, 2009).

Uncomplicated (normal) grief, therefore, is the objective reactions and subjective experiences following bereavement that are consistent with expected cultural norms and with consideration of variables related to the death, the trajectory of time, and the intensity of

symptoms (Horwarth, 2011; Servaty-Seib, 2004; Stroebe et al., 2008). Objective reactions and subjective experiences of uncomplicated grief and its impact following the loss of a loved-one to death, according to bereavement literature and grief research, are extensive (Drenth et al., 2010; Granek, 2010; Humphrey, 2009; Currier, Neimeyer & Berman, 2008; Stroebe et al., 2008; Worden, 2009).

Descriptive Manifestations Related to Loss Due to Death

The present body of research offers many descriptive manifestations of grief and personal resolutions related to loss due to death. An example of descriptive grief manifestations is noted by Bonanno and Kaltman (2001). Bonanno and Kaltman performed a review of descriptive studies of the grieving process and identified the following four types of disruptive functioning: cognitive disorganization, dysphoria, health deficits, and disruptions in social and occupational functioning. Buglass (2010), Dunne (2004), and Worden (2009) identified descriptive manifestations of the grieving process such as sadness, loneliness, decreased appetite, increased fatigue, and inability to sleep; all of which were identified by Bonanno and Kaltman in previous works. Parkes (2011) highlighted that the frequency of the occurrence of depression and despair during bereavement is so prevalent that the diagnosis of major depression in the *Diagnostic and Statistical Manual of Mental Health Disorders IV-TR* (DSM-IV-TR; APA, 2000) is disallowed before a period of at least two months has transpired. This two-month grace period can potentially allow time for personal resolution of grief and can allow time to make a distinction between similar symptoms of normal grief and depression. The DSM – 5 has removed the bereavement exclusion for depression permitting its diagnosis weeks following the death (APA, 2013).

Despite the normal conception of the bereavement experience, many persons seek assistance to manage the associated grief reactions that can have physical, emotional, cognitive, behavioral, sexual, and spiritual components, varying in length and disruptiveness (Dent, 2005; Silverberg, 2007; Worden, 2009). Additionally, a small subset (10-15%) of bereaved persons' experiences are beyond what is considered normal or uncomplicated (Boelen et al., 2007; Lobb et al., 2010; Shear, Boelen, & Neimeyer, 2011; Worden, 2009). This type of grief experience is referred to as prolonged, chronic, or complicated grief (Shear et al., 2011; Worden, 2009). A distinguishing factor of uncomplicated and complicated grief is the degree of disequilibrium in human functioning following the death (Bonnano & Kaltman, 2001; Drenth, 2010; Worden, 2009).

Though many people are experiencing a period of bereavement at any given time, most bereft people advance through bereavement without any residual problems (Bonnano et al., 2004; Cutcliffe, 2004; Parkes, 2011). That is, many people are able to achieve personal resolution of loss-related issues and challenges and resume a meaningful fulfilling life without outside intervention. Personal resolution is individualized recovery from the effects of loss resulting from the major life event of death (Burnett et al., 1997). For some, personal resolution of bereavement issues is achieved by sources outside of personal resilience, such as the predictor variables under scrutiny in this study (i.e. individual counseling, participation in grief support groups, perceived level of social support received, and overall level of hope).

Brooke (2001) and Rando (1991) concurred with Angelou's (1994) view that there is value in being cognizant of the timeliness of life and the value in achieving personal resolution of losses. That is, the option is available to spend time investing in measures that will produce personal resolution of grief (e.g., the variables of this study) versus spending extended time in

the throes of grief that are counter-productive to personal resolution of the loss. Brooke (2001) underscored that the length of time spent grieving losses can subtract from time spent enjoying living in her book titled *Don't Let Death Ruin Your Life*. Likewise, Rando (1991) accentuated getting back to living following the death of a loved one in her book titled *How to Go On Living When Someone You Love Dies*, thus lending support for the relevance of personal resolution of grief. This leaning toward timely grieving is also acknowledged by Granek (2010). Granek suggested that the view endorsing timely personal resolution of grief, including a return to being a fully functioning contributing member of society in the most cost efficient manner possible, is widely held.

Personal Resolution

The initiators of grief research, Freud (1957), Lindemann (1944), and Bowlby (1980) shared a belief that through grief work a resolution of grief could be achieved. Grief work refers to the bereaved absorbing and confronting the raw emotions of grief and relinquishing the bond with the deceased loved one (Bowlby, 1980; Freud, 1957; Lindemann, 1944). The grief work hypothesis was not embraced until the late 1990s during which most interventions for the bereaved were compatible with theories that endorsed confrontation strategies and severing ties with the deceased (Stroebe & Stroebe, 1991). For example, Ramsay's (1997) *flooding technique* represents a bereavement intervention of *grief work* used in the treatment of the bereaved to achieve personal resolution of grief.

Stroebe and Schut (1999), in response to research that regarded the sole necessity of grief work to achieve personal resolution of grief during bereavement, developed the dual-process model (DPM) of bereavement. Though not completely in support of *grief work* as defined by the intitial grief researchers, the theoretical underpinning of the dual process model of coping

with bereavement does include the theory of the grief work hypothesis (Humphrey, 2009; Stroebe & Schut, 1999). According to Stroebe and Schut (1999), the DPM addressed the limitations in scientific representation of bereavement phenomena, that is, the lack of empirical testing and lack of universal application. The DPM includes the necessity of confronting the grief of loss, yet adds a component for confronting the realities of dealing with life without the deceased. This model was originally developed to understand coping from the perspective of widowhood but has been determined to be effective for other types of losses as well (Stroebe & Schut, 1999; Stroebe & Schut, 2010).

The basis of the DPM model, for the achievement of personal resolution of grief during bereavement, is an alternating process of investing time, energy, and concentrated focus between some aspect of the loss experience (life before the death) and what remains (life now and in the future). The process, which culminates into the personal resolution of bereavement-related grief, proposed by the DPM is composed of confronting and avoiding the stressors related to loss and restoration (Bennett, Gibbons, McKenzie-Smith, 2010; Drenth et al., 2010; Doughty, Wissel, & Glorfield, 2011; Dunne, 2004; Humphrey, 2009; Stroebe & Schut, 1999).

Loss-oriented, grief-related stressors and behaviors can include focusing on the relationship with the deceased person, rumination about the deceased, and circumstances surrounding the death. Looking at pictures, crying, anger at the deceased or God, and many other emotions and behaviors, with respect to the deceased person, also fall under the category of loss-oriented coping (Stroebe & Schut, 1999). Restoration-oriented grief-related stressors and behaviors include adjustments to changes that are secondary losses consequences, such as adapting family roles including things such as finances, laundry, and cooking; learning new skills such as dealing with arrangements for perpetual issues such as maintenance of home and

automobiles; and a change in identity such as from a spouse to a widow (Bennett et al., 2010; Doughty et al., 2011; Drenth et al., 2010; Humphrey, 2009; Stroebe & Schut 1999). Likewise, Bonanno et al. (2004), Dunne (2004), Servaty-Seib (2004), and Carnelley, Wortman, Bolger, and Burke (2006) similarly viewed personal resolution of grief as including some form of acceptance and adaptation.

Though lacking the specificity detailing how the acceptance and adaptation process is accomplished such as offered by Stroebe and Schut in their dual process model (DPM), Bonanno and Kaltman (2001) referenced a return to baseline levels of functioning by the end of the first year as indication that personal resolution of bereavement-related grief has been achieved. Akin to the theme of an acceptance and adaptation process to achieve personal-resolution of bereavement-related grief, Carey (1977) developed a scale, using a qualitative approach, to measure the adjustment of widowed persons after one year describing the outcomes as superior adjustments. Carey (1977) conducted this study in an effort to develop a single self-report measure of adjustment to help physicians and counselors predict which spouses would have the hardest time during bereavement. The interview was conducted 13 - 16 months after the subjects were widowed and consisted of 78 widows and 41 widowers, ages 28 - 70.

Personal resolution is operationalized in the literature as the achievement of clinically significant improvement on grief outcome variables in areas of grief symptoms, interpersonal distress, social functioning, self-esteem, and quality of life (Joyce, Ogrodnicuzuk, Piper, & Weidman, 2009). Joyce et al.'s (2009) study showed that nearly half of the 110 bereaved persons in the sample achieved clinically significant personal resolution of grief. Sands and Tennett (2010) operationalized personal resolution as the accomplishment of reengagement in daily life and refocusing on the positive aspects of their relationship with the deceased. Personal

resolution is described by Worden (2009) as Task IV of mourning in the task model of bereavement, "To find an enduring connection with the deceased in the midst of embarking on a new life" (p. 50). Worden's (2009) task model is based on adaptation to loss. That is, a reconciliation process through the accomplishments of specific tasks during bereavement which lead to the achievement of a meaningful and fulfilling life without the physical presence of the deceased (Altimer, 2011; Horwarth, 2011; Worden, 2009).

Neimeyer (2000, 2006, 2009, 2012), having conducted extensive research on the topics of grief and loss, offered a contrasting view to literature that support the amelioration of grief symptoms as the precursor to successfully moving forward in life. Furthermore, Neimeyer (2009) added depth and quality to the personal resolution of grief through the development of the constructivist theory and meaning making. The constructivist theory is undergirded by the human capacity to interpret life using past experiences, present experiences, and expectations for future experiences. Granek (2010), similarly to Neimeyer, linked the capabilities of humans to experience life as a defining feature of the grief experience. Granek (2010) referred to grief as natural kind and human kind. Natural kind is found in nature and transformed into human kind (Granek, 2010; Hacking, 1995).

The capability to live in a world that can be represented with words in terms of a personal story, with simultaneous consideration of these three realms, according to Neimeyer (2009) and Neimeyer and Sands (2011), is a person's assumptive world. The assumptive world represents how each person experiences, interprets, and communicates meaning of events in his or her life. When the assumed order and meanings of life events are interrupted by an unwelcome change in a person's story, such as the sudden death of a loved one, some persons experience dissonance and distressing grief. The search for meaning as it relates to the change in the assumptive-world

story during bereavement is a common reaction (Neimeyer, 2009; Neimeyer & Sands, 2011). Personal resolution of grief and loss, according to the constructivist view, is achieved once the loss can be integrated into the reconstructed story with reestablished order. Thereby, momentum is restored for reengagement in a renewed meaningful assumptive-world life with a *revised self-narrative* (Neimeyer, 2009; Neimeyer & Sands, 2011).

According to Neimeyer (2000, 2006, 2009, 2012) and Neimeyer and Sands (2011), often there is a search for meaning to unwelcomed changes thrust into our lives such as the death of a loved-one. Meanings include a *back story* in attempts to review shared history to determine how this happened (Neimeyer & Sands, 2011). Also included in meanings is an *event story* detailing what happened and an *unknown future story* in-the-making involving accommodation of the death and defining who the bereaved becomes after personal-resolution of the loss (Neimeyer & Sands, 2011). The absence of searching for meaning is an indicator of a positive bereavement outcome (i.e. personal resolution of the loss; Neimeyer & Sands, 2011).

The hope literature addresses personal resolution differently than the bereavement literature and the constructivist theory perspective. The period of bereavement and the subsequent experience of grief can present challenges and obstacles that must be overcome; thus making hope theory applicable to the personal resolution of grief. Snyder (2002), a hope researcher, put forth that psychological adjustment outcomes are higher when consistent hope is present. Furthermore, Snyder deemed confidence in one's ability and hopeful thinking are valuable tools for achieving goals when people are dealing with challenges and obstacles encountered, such as those that prohibit personal resolution during bereavement.

The challenges and obstacles encountered during bereavement can present significant barriers to achieving personal resolution for the experience of grief. As a person experiences

problems associated to bereavement that appear to be unyielding to current coping strategies, the difference in hope levels can influence whether the person achieves personal resolution of the loss. High-hope persons will devise alternative ways to achieve goals (pathway thinking) and maintain momentum and confidence (agency thinking) toward goal achievements (Snyder, 2002). Conversely, low-hope persons are not as likely to engage in alternative ways to solve problems (pathways thinking) and often succumb to discouragement with resulting negative and discouraging emotions, not confident goal can be achieved (agency thinking). The end result is the low-hope person is less likely to achieve goals for personal resolution of grief. High-hope persons are more likely to achieve goals than low hope persons (Snyder, 2002). Therefore, high-hope persons have a higher chance of achieving personal resolution among people who have experienced a loss through death than those who are low-hope persons.

In conclusion, personal resolution includes increased self-esteem, confidence, control over life, and appreciation of coping abilities (Clark & Goldney, 1995); learning to deal with problems and a return to normal level of functioning (Bonanno & Kaltman, 2001); acceptance, balance, and flexibility (Servaty & Seib, 2004); reaching a state of acceptance (Carnelley et al., 2006); and "a resigned acceptance of the reality of death" (Neimeyer, 2006, p. 9). Therefore, the underlying theme of personal resolution in the bereavement literature is an improved state of adjustment to the loss that is acceptable for each bereaved person.

Individual Counseling

The literature is mixed in regard to support for the benefit of individual counseling for the bereaved population. Some researchers, such as Cutcliffe (2004), maintain that individual counseling is a precursor to accomplishing a completed bereavement reaction. To the contrary, Bonanno et al. (2004) conducted a study that revealed large numbers of bereaved individuals are

capable of genuine resilience in the face of loss without any form of counseling. The findings of Bonanno et al. (2004) concurred with those of Stroebe and Stroebe (1991), which, in a study of 60 widowed individuals, did not fully support individual counseling for the bereaved.

Larson and Hoyt (2007) conducted a literature review and meta-analysis to further examine negative claims regarding the efficacy of bereavement counseling. Their results showed no statistical or empirical foundation for claims that dismissed grief counseling as a viable and beneficial means to address bereavement-related grief (Larson & Hoyt, 2007). Likewise, researchers Currier et al. (2008) conducted a meta-analysis summarizing results from all current available ($n = 61$) controlled outcome research on grief therapies. The results, of the most comprehensive summary of the literature that was available, showed of the four overall analyses, bereavement interventions out performed no-intervention control groups (Currier et al., 2008).

Jordan and Neimeyer (2003) summarized the findings of four recent reviews in the bereavement literature that indicated a lack of efficacy for grief counseling. The first summation included perhaps counseling was not needed since only a very small percentage of the bereaved need formal intervention (Jordan & Neimeyer, 2003). Secondly, the timing of grief counseling may be the reason for the inefficacy of results (Jordan & Neimeyer, 2003). For example, most intervention-studies of grief counseling, individual or group, occurred over a period of eight to ten sessions in eight to ten weeks (Jordan & Neimeyer, 2003). Jordan and Neimeyer proposed that perhaps the therapy was inadequate in sessions and time to "produce measurable effects" (p. 774).

Ober, Granello, and Wheaton (2012) stated that the ability of a counselor to help clients adjust to grief is a critical skill that will be in higher-demand in future decades. These researchers surveyed 369 counselors to investigate training, experience, and competency (Ober et al., 2012). The results revealed slightly more than half lacked any formal training to deal with loss, and the remaining 45% had at minimum one course (Ober et al., 2012). Though mixed views of the efficacy of individual counseling for the bereaved population exists in the literature, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) is silent on this issue, and it does not mandate specific training for counseling programs in the area of grief and loss (Doughty et al., 2011).

"Whatever one's philosophy of grief counseling and whatever the setting, there are certain principles and procedures that help make grief counseling effective" (Worden, 2009, p. 89). Some interventions help clients actualize the loss using counseling skills such as active listening, demonstrating empathy, asking open ended questions surrounding the loss events, and consistent with cultural beliefs. Interventions also help clients identify and experience feelings such as feelings of negativity, anger, guilt, anxiety, and helplessness. These are achieved employing counseling skills such as of exploration of thoughts and feelings about the loss, and validating and normalizing. Problem solving skills can facilitate the griever's efforts to live without the deceased. The counselor can strategize with the griever to come up with ways to deal with meaningful events and holidays consistent with and respectful of client's cultural and other beliefs. Individualizing therapy, as grieving is highly individualized, and being cognizant of time since loss and timeliness of interventions are also very important when counseling the bereaved (Neimeyer, 2000; Worden, 2009). Additionally, examining defenses and coping styles and assisting clients to evaluate their effectiveness and exploration of other possible avenues for

managing the stressors of grief (Worden, 2009). Lastly, identify pathology and refer is also very important (Worden, 2009).

The bereavement and grief research and literature support the following four models as the most widely used bereavement models by counselors and professionals who practice counseling in the area of bereavement: 1) the dual process model; 2) task-oriented models; 3) phases models; and 4) stages models (Doughty et al., 2011; Drenth et al., 2010; Humphrey, 2009; Neimeyer & Currier, 2009; Maciejewski, Zhang, Block, & Prigerson, 2007). Drenth et al. (2010) research study's aim of giving a condensed literature review on the most significant bereavement models/approaches listed the preceding models as "most important" (p. 2). Stroebe et al. (2008) also listed the preceding four models of bereavment in their book, *Handbook of Bereavement Research and Practice: Advances in Theory and Intervention,* which includes the examination and application of bereavement research in the 21st century, reflective of "up-to-date and state-of-the-art" information (p. 3).

Humphrey (2009) provided support for inclusion of the dual process model as one of the most widely used grief models declaring it is "highly recommended to counseling professionals" (p. 37). Neimeyer and Currier (2009) conducted a recent comprehensive analysis of over 60 controlled studies and identified the dual process model as being associated with more effective bereavement interventions.   "The stage theory of grief remains a widely accepted model of *bereavement adjustment* still taught in medical schools, espoused by physicians, and applied in diverse contexts" (Maciejewski et al., 2007, p. 716). Currently, the Council for Accreditation and Related Educational Programs (CACREP) does not require specific training in the area of grief and loss and many practicing counselors continue to utilize stage models in grief counseling such as Kubler-Ross's 1969 five stages of grief (Doughty et al., 2011). In summary, regardless

of the theoretical-approach to therapy, individual counseling is among the choices the bereaved can make to work towards achieving personal resolution of loss-related grief.

Grief Support Groups

Support groups were officially recognized in the counseling profession as a viable means to help people cope with problems in life in 1905 (Gladding, 2009). According to Corey and Corey (2006), Markus and King (2003), and Piper and Ogrodnicuk (2004), group psychotherapy and individual therapy produce parallel positive outcomes for a variety of psychological problems (e.g., psychological problems related to complicated grief). Corey and Corey further deemed that many referrals for counseling and psychotherapy are grief related.

A grief support group is where people who are bereaved meet to garner and lend support to fellow grievers. Thus, grief support groups are settings where the receipt of psychological support is available as a viable contribution to personal resolution of grief due to the loss of loved-ones. Grief support groups come in many forms and sizes. Some are for specific types of losses, such as parents or widows, and others are open to anyone regardless of type of loss. Wolfelt (2003) described grief supports groups as "invaluable" (p. 98) in terms of the contribution to personal resolution of bereavement-related grief. Wolfelt further delineated that support groups led by skilled leaders generally exceeded the expectations of benefit for many people.

Grief support groups are a safe place for emotional expression where one finds understanding as well as feel understood. Participation in grief support groups also addresses social isolation (Hoy, 2007; Humphrey, 2009; Worden, 2009), a common issue during bereavement. That is, they provide a sense of belonging and provide a venue to make new

connections and build new relationships. A further function of grief support groups is provision of a place to remember (Hoy, 2007). Quite to the contrary of what one may think, a lot of sharing happy memories, stories, and photographs in grief support groups occur in grief support groups (Worden, 2009). A grief support group is a place where those who have lost a loved-one are presented with options that lead to choices, control, empowerment, and personal resolution of grief.

References

Altimer, E. (2011). Best practices in counseling grief and loss: Finding benefit from trauma. *Journal of Mental Health Counseling, 33*(1), 33-45.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington: American Psychiatric Association.

Angelou, M. (1994). Wouldn't take nothing for my journey now. New York: Bantam Books.

Boelen, P. A., Keijer, J. d., van den Hout, M., & van den Bout. (2007). Treatment of complicated grief: A comparison between cognitive-behavorial therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 75*(2), 277-284.

Bonanno, G.A., & Kaltman, S. (1999). Towards an integrative perspective on bereavement. *Psychological Bulletin, 125*(6), 760-776.

Bonanno, G.A., & Kaltman, S. (2001). The varieties of grief experience. Clinical Psychology Review, 21(5), 705-734.

Bonanno, G.A., Wortman, C.B., & Nesse, R.M. (2004). Prospective patterns of resilience and maladjustment during widowhood. *Psychology and Aging, 19*(2), 260-271.

Bowlby, J. (1969). *Attachment and loss, volume 1: Attachment.* New York Basic Books.

Brooke, J. (2001). *Don't let death ruin your life. A practical guide to reclaiming happiness after the death of a loved one.* New York: Penguin Group.

Burnett, P., Middleton, W., Raphael, B., & Martinek, N. (1997). Measuring core bereavement phenomenology. *Psychological Medicine, 27,* 49-57.

Centers for Disease Control, National Vital Statistics Report. (2012). Deaths: Preliminary data

for 2011 (NVSR Publication).   Retrieved from

http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf

Cohen, J. (1992). Quantitative methods in psychology. *Psychological Bulletin, 112*(1), 155-159.

Currier, J. & Neimeyer, R. & Berman, J. (2008). The effectiveness of psychotherapeutic

interventions for bereaved persons: A comprehensive quantitative review. *Psychological*

bulletin, *134*, 648-61. doi:10.1037/0033-2909.134.5.648

Cutcliffe, J.R. (2004). The inspiration of hope in bereavement counseling. *Issues in Mental*

Health Nursing, 25, 165-190.

Dent, A. (2005). Supporting the bereaved: Theory and practice. *Counseling at Work,* 22-23.

Doka, K J. (2000). Living with grief: Children, adolescents, and loss. New York: Brunner/Mazel.

Drenth, Herbst, C. H. & Strydom, H. (2010). A complicated grief intervention model. Journal of

Interdisciplinary Health Sciences. 15(1), 62-69. Dunne, K. (2004). Grief and its

manifestations. Nursing Standard, 18(45), 45-51.

Dunne, K. (2004). Grief and its manifestations. Nursing Standard, 18(45), 45-51.

Dutton, Y. C., & Zisook, A. (2005). Adaptation to bereavement. *Death Studies, 29,* 877-903.

Granek, L. (2010). Grief as pathology: The evolution of grief theory from freud to present.

History of Psychology, *13*(1), 46-73.

GRASP, *Grief Recovery After a substance passing.* Retrieved from: http://grasphelp.org/

Healy, D. (2012). Melancholia: Past and present. *CanJPsychiatry, 58*(4), 190-194.

Howarth, R. (2011). Concepts and controversies in grief and loss. *Journal of Mental Health*

Counseling, 33(1), 4-10.

Humphrey, K. (2009). *Counseling strategies for loss and grief.* Alexandria, VA: American
Counseling Association.

Jacobs, E. E., Masson, R. L, & Harvill, R. L. (2002). *Group counseling.* Pacific Grove: CA.

Jordan, J. R., & Neimeyer, R. A. (2003). Does grief counseling work? *Death Studies, 27*, 765-
786.

Kissane, D.W., Bloch, S., Dowe, D. L., Snyder, R. D., Onghena, P., McKenzie, D.P., Wallace,
C.S. (1996). The Melbourne family grief study, I: Perceptions of family functioning in
bereavement. *The American Journal of Psychiatry, 153*(5), 659-666.

Mostofsky, E., MacClure, M., Sherwood, J.B., Tofler, G.H., Muller, J.E., & Mittleman, M.A.
(2012, March). Risk of acute myocardial infarction after the death of a significant person
in one's life. *Perspectives in Public Health, 132*(2), 491-496. Retrieved from
http://circ.ahajournals.org

Neimeyer, R. A. (2009). *Constructivist psychotherapy.* NY: Routledge.

Neimeyer, R. A. (2012). Techniques of grief therapy: Creative practices for counseling the
bereaved. New York, NY: Routledge.

Neimeyer, R. A. (2006). Lessons of loss. Memphis, TN: Center of Loss and Transition.

Neimeyer, R. A., & Sands, D. C. (2011). Meaning reconstruction in bereavement: From
principles to practice. In Neimeyer, R. A., Harris, D. L., Winokuer, H. R., & Thornton,
G. F. *Grief and bereavement in contemporary society: Bridging research and practice*
(pp. 9-22). New York, NY: Taylor and Francis Group, LLC.

Parks, C. L., & Halifax, R. J. (2011). Religion and spirituality in adjusting to bereavement: Grief

    as burden, grief as gift. In R. A. Neimeyer, D. L. Harris, H. R. Winokuer, & G. F.

    Thornton (Eds.). *Grief and bereavement in contemporary society: Bridging research and*

    practice (pp. 355-363). New York, NY: Taylor and Francis Group, LLC.

Parkes, C. M. (1985). Bereavment. *British Journal of Psychiatry, 146,* 11-17.

Parkes, C. M. (2006). *Love and loss: The roots of grief and its complications.* New York: Taylor

    and Francis, Inc.

Parkes, C. M. (2011). Introduction: The historical landscape of loss: Development of

    bereavement studies. In Neimeyer, R. A., Harris, D. L., Winokuer, H. R., & Thornton, G.

    F. *Grief and bereavement in contemporary society: Bridging research and practice*

    (pp.1-5). New York, NY: Taylor and Francis Group, LLC.

Prigerson, H.G., Bierhals, A.J., Kasl., S.V., Reynolds, C.F, Shear, M.K., Day, N., …Jacobs, S.

    (1997). Traumatic grief as a risk factor for mental and physical morbidity. *The American*

    Journal of Psychiatry, 154(5), 616-623

Rando, T. A. (1991). *How to go on living when someone you love dies.* New York. Bantam

    Books.

Rosenblatt, P., & Wallace, B. (2005). *African American grief.* New York: Brunner Routledge.

of grief and mourning. *Journal of Mental Heatlh Counseling*, *26*(2), 125-145.

Servaty-Seib, H. L. (2004). Connections between counseling theories and current theories of

    grief and mourning. *Journal of Mental Heatlh Counseling, 26*(2), 125-145.

Shear, M.K. (2009). Grief and depression: Treatment decisions for bereaved children and

    adults. *The American Journal of Psychiatry, 166*(7), 746-748.

Silverberg, E. (2007). Introducing the 3-A grief intervention model for dementia caregivers: Acknowledge, assess, and assist. *Omega, 54*(3), 215-235.

Stroebe, M.S., Hansson, R.O., Schut, H., & Stroebe, W. (2008). Bereavement research contemporary perspectives. In M. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe. (Eds.). *Handbook of bereavement research and practice: Advances in theory and intervention.* (pp. 3-25). Washington, DC: American Psychological Association.

Stroebe, M., & Schut, H. (2001). Models of coping with bereavement: A review. In M. Stroebe, R. O. Hansson, H. Schut, & W. Stroebe. (Eds.). *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 375-403). Washington, DC: American Psychological Association.

Weiss, R. (2008). *The nature and causes of grief.* In Stroebe, M., Hansson, R.O., Schut, H., & Stroebe, W. (Ed.s.), *Handbook of bereavement research and practice: Advances in theory and intervention* (pp. 29-44). Washington, DC: American Psychological Association.

Worden., W. J. (1996). *Children and grief: When a parent dies. NY:* Guilford Press.

Worden, W. J. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner.* New York: Springer Publishing Company, LLC.

Zech, E., & Arnold, C. (2011). Attachment and coping with bereavement: Implications for therapeutic interventions with the insecurely attached. In R. A. Neimeyer, D. L. Harris, H. R. Winokuer, & G. F. Thornton (Eds.), *Grief and bereavement in contemporary society: Bridging research and practice* (pp. 23-35). New York, NY: Taylor and Francis Group, LLC.

Insufficient Depth of Life Skills Training for Foster Care Graduates

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Abstract

Children are often placed in foster care because they have "suffered abuse, neglect, abandonment, or the loss of a parent" (Keller, Cusick, & Courtney, 2007, p. 455). The expectation of foster care is that the removal of children from inadequate and/or substandard conditions will provide them with holistic wellness and a quality life as adults. Many foster care graduates struggle to maintain self-sufficiency; this outcome suggests that there are deficits in this well intended social service. Life skills attainment is one of the necessary contributors to self-sufficiency. This transcendental phenomenological study examines the lived experiences of foster care graduates in learning how to complete most life skills, under normal circumstances on most days without assistance. In other words, foster care graduates with an insufficient depth to their life skills training while in foster care and suggestions to improve their life skills training.

Insufficient Depth of Life Skills Training for Foster Care Graduates

Foster care is designed to provide childhood victims of abuse or neglect a safe and productive environment to develop holistically until they can either return to their parent or be adopted. Holistic care of foster children involves the physical, emotional, mental, and spiritual wellness of previously traumatized children through counseling, educational support, and community involvement (Katz, 2011). However, many foster care graduates endure poverty, school withdrawal, substance abuse, generational foster care, incarceration, and early death. It is reasonable to assume that each of these factors is the direct result of the foster care graduates' life skills attainment while in foster care.

The purpose of this study is to better understand the deficits in the depth of life skills training for foster care children. This study utilizes the perspectives of foster care graduates because their experiences, as adults, gives the best depiction of the depth of their life skills training and the implications of it. Ultimately, enhancing the life skills attainment of foster children will have a positive impact on the descendants of future foster care graduates and the communities in which they reside. The Institutional Review Board approved for this researcher to utilize snowballing, church announcements, and news and radio segments in Birmingham, Tuscaloosa, Montgomery, and Mobile Counties to collect data. The other methods were not pursued given the effectiveness of snowballing. Data collection, in this manner, allowed research participants to refer their friends and relatives to participate in this study. This form of data collection was selected because foster care graduates might be "visible but hidden" or disenfranchised from the communities in which they live by homelessness, poverty, illiteracy, criminality, and so on and so forth. Additionally, this form of data collection allows foster care graduates who might have had similar experiences while in the child welfare system to either

corroborate or contradict the experiences of their peers. The central question of this study is "What is the experience of obtaining depth to life skills training while in foster care?" This study also makes recommendations to counselors and researchers to challenge these deficits.

Literature Review

Child Welfare System

Children enter into the foster care system when a parent reports an inability to provide supervision and basic needs for their child, a community member or relative reports the inability of a parent to care for a child, or all identified parents die without establishing a guardian for their child. The inability to provide supervision and basic needs may be related to the inability of the parent to provide food, shelter, clothing, and utilities to their child; however, it could also mean a lack of supervision of a child while their parent works, the debilitating health of a parent, or the inability to avoid substance use (U. S. Department of Health and Human Services, 2016). The children of incarcerated parents are also placed in foster care if a biological relative or like-relative cannot be identified or approved by child welfare services as a suitable housing option for that child (Chapman, Wall, & Barth, 2004).

In addition, children may need out of home care due to their inability to control impulsive and dangerous behaviors, such as physical aggression, substance abuse, fire-setting, and sexual victimization (Chapman et al., 2004). Children with impulsivity issues would need to demonstrate an ability to comply with societal norms before 18 years of age to be considered for a return to their parent (Chapman et al., 2004). After removal from home, foster care is designed to find permanency for that child, or in other words, permanent support for the remainder of the child's life (Department of Social Services, 2016). Permanency options include

reunification with a parent, adoption, placement with a relative or like-relative, a foster parent, or a therapeutic facility (Department of Social Services 2016).

Developing Life Skills

Life skills are techniques designed to increase an individual's capacity to live without guardianship (Barnow, Buck, O'Brien, Pecora, Ellis, & Steiner, 2013; Casey Life Skills, 2016; Courtney Dworsky, Brown, Cary, Love, & Vorhies, 2011). These skills include healthy relationship, work, study, long-term and day to day planning, money management, computer literacy, and being able to utilize community resources (Casey Life Skills, 2016). Foster care children, by definition, have been exposed to poor parenting techniques, inadequate housing, substance use, or other factors that the child welfare system determined would have a negative impact on their ability to have adequate guidance (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). Foster care youth with inadequate guidance are likely to have developed an appreciation for the inadequate skills taught to them, directly or indirectly, by their parents (Casey Life Skills, 2016). Some examples of ineffective life skills attainment due to poor guidance include stealing food or money, pandering for income, malnourishment, and poor nutritional goals. It may be difficult for foster care children, as well as anyone else, to abandon skills that they believe are helpful.

A commonly used life skills program, in the foster care system, is the Casey Life Skills program (Courtney et al., 2011). The Casey Life Skills program utilizes a self-report questionnaire to determine life skills deficits according to the child (Casey Life Skills, 2016). The concern regarding this approach are that self-report measures lack the validity of other evaluative measures and is subjected to bias. The Casey Life Skills program also provides some

instructional resources to assist the life skills trainer in teaching the life skills to the child (Casey Life Skills, 2016). However, the child may have an inadequate perception of their life skills strengths and needs. Furthermore, the child may be resistant to learning more information about life skills that they have already identified as their strengths.

Some foster care programs have limitations to how much life skills exposure foster children receive daily (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). For instance, some foster care programs have a business office that monitors daily expenses and pays bills on behalf of the youth (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). Foster care youth in this type of environment may feel disconnected by having to postpone wants until money can be earned to address their concerns. Additionally, they may have difficulty in determining the cost of their day-to-day life and imaging how to create a monthly budget to address their needs. These examples pertain more to foster care placements in large residential facilities (Casey Life Skills, 2016). In residential facilities, there are teams of individuals that assist the foster child in accessing health care, medication, food, domestic care, recreation, and so forth (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). It would be difficult to imagine a foster child in this environment having an in-depth understanding of the operations of each department, to the extent that they can execute these skills after care.

Foster care youth in single-family homes may have a more traditional upbringing and may have some exposure to what it takes to implement life skills (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). However, the care of foster care youth in single-family homes is still dictated by the Individualized Service

Plan (ISP) written by the social worker (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). The degree of life skills exposure experienced, in either setting, is based on the specific instructions found on the ISP (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). Therefore, foster care youth in single-family homes may not be encouraged to investigate how to address life skills if it is not written into their ISP goals. It is critical that researchers understand the role that this ambiguity plays in life skills attainment for foster care youth.

There is no clear rubric that dictates action steps to successfully achieve a skill or what to do when a skillset is insurmountable for a child, for instance a child with a disability. It does not have a quantifiable measure that identifies children that will struggle to thrive after their emancipation. The Casey Life Skills program does not have a mandated administrator training and has few instructional materials to support the training needs of foster children completing the program (Casey Life Skills, 2016). These instructional materials are ideal for seminars; however, foster care children may lack frequent tangible experience of performing these skills as their peers who remained in their homes might experience.

The State of Alabama requires foster care children to participate in the Independent Living Program (ILP) which begins life skills training at age 14 (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). ILP continues until the youth reaches emancipation and leaves the foster care system. ILP consists of one seminar per month on a single topic in which the nearest Department of Human Resources schedules an expert. The State of Alabama requires the expert to perform the life skill in which they are lecturing as a regular portion of their job description (Alabama Department of Human Resources, 2016; S. Gilbert, personal communication, December 28, 2016). The expert is sought out by

local social workers to volunteer their expertise with no specific guidelines from child welfare regarding the topic, content, scope, and the sequence in which the life skills are to be discussed. There may be several months before the same life skill is practiced with an expert again. Foster care children are paid $10 to participate in the ILP, but the expert is an uncompensated volunteer. The ILP session often takes place in the Department of Human Resources office due the liability of having children practicing skills in real-life settings and company policies that discourage the use of work equipment for non-work related purposes. This arrangement limits the foster care children to lectures that do not require equipment. Therefore, foster care children may have limited training in areas such as cooking, ironing, making a bed, utilizing an ATM, and many others.

Graduating from Foster Care

Foster care youth can be reunified with their biological family members or be adopted (Ala. Code § 26-13-1). Foster care youth that are reunified with a parent typically return to the care of their parent after the parent demonstrates their ability to provide adequate supervision and safety to their child (Ala. Code § 26-13-1). The child must also demonstrate an ability to be governable while in their out-of-home placement (Ala. Code § 26-13-1). These children are considered to have graduated from the foster care system because they are thought to have the necessary support and materials to be nurtured without the supervision of the child welfare system (Ala. Code § 26-13-1). This title is also given to children who leave foster care as a result of being adopted (Ala. Code § 26-13-1). For a foster child to be adopted, the adoptive family would have to prove their ability to emotionally and physically nurture the child (Ala. Code § 26-13-1). Once adoption occurs, the family assumes full responsibility of the adoptive child, including financial support (Ala. Code § 26-13-1). Foster graduates, who are still children,

and their parents may continue to need medicinal, financial, or therapeutic support to maintain a healthy lifestyle. Medicinal, financial, or therapeutic supports might include psychotropic medications, food stamps, welfare-to-work programs, and counseling. Child welfare services seeks to affirm the ability of the family to thrive even with multiple service providers (Ala. Code § 26-13-1). These individuals are still viewed as children and are not perceived any differently than children who never left the supervision of a parent (Ala. Code § 26-13-1).

Ideally, a child that leaves foster care before becoming an adult has the same opportunity to gain life skills as a child who remains in foster care until adulthood. However, a child that returns to family care or is adopted, may have more exposure to real life settings in which life skills can be taught. In contrast, a child that is not governed by a service plan may not be encouraged or motivated to refine their life skills attainment. It is worth pondering if leaving foster care prior to becoming an adult enhances or hampers the attainment of life skills. However, some individuals will remain in foster care until they reach the legal age of adulthood. A petition has been reviewed and accepted granting the foster care child an emancipation. The emancipation declares that the individual is a graduate of the foster care system and that they are entitled to the freedoms of any adult member of society (Ala. Code § 26-13-1). It also indicates that the individual can obtain and maintain health benefits, housing, employment, post-secondary educational training, and family or like-family support without assistance from DHR (Ala. Code § 26-13-1).

The relationship between life skills attainment and emancipation is that there are no mandates that specify that self-sufficiency must be achieved before State custody ends. Clearly stated, a plan to create self-sufficiency is no more than an idea that self-sufficiency might be possible within ideal circumstances. It is worth pondering what emancipated adults are expected

to do when their ideal plan fails and they are no longer entitled to the support systems available to them as a child.

Methods

Participants in this research study needed to have at least 12 consecutive months of relative or non-relative foster care in the State of Alabama. Participants were required to be between 19 and 26 years of age and willing to discuss their experiences in an audio-recorded interview. The six categories of life skills are daily living, self-care, relationships and communication, housing and money management, work and study, and career and education planning skills. A chart (see figure 1) was utilized to verbally explain the life skills categories and the sub-descriptors of each of these categories. The researcher was the only person to view this chart to avoid research participant bias in their responses. This researcher will assist participants in understanding these 6 categories by describing these skills sets and the subskills they entail before asking the interview questions for each category.

Daily Living Skills	Self-Care Skills	Relationship & Communication Skills	Housing & Money Management	Work & Study Skills	Career & Education Planning
Food & Nutrition Home Cleanliness Home Safety Home Repairs Computer & Internet Basics Daily Living Permanency	Health Care Personal Benefits Personal Hygiene Personal Safety Sexuality	Personal Development Developing Relationships Communication with Others Cultural Competency Domestic Violence Legal Permanency	Budgeting & Spending Plan Banking & Credit Housing Transportation	Study Skills Employment Time Management Personal Development Income Tax Legal	Education Planning Career Planning

Figure 1. Chart of Life Skills

These interview questions are 1.) How capable were you of executing these tasks before foster care placement, 2.)How did you make improvements in these skills while in foster care, 3.)What supports did you have while in foster care to improve these skills, 4.)Why did or didn't

you ask for assistance with these skills while in foster care or at discharge, and 5.)Please give examples of ways that you were impacted by your ability to demonstrate these skills after you left foster care? Each of the six categories of life skills had the same questions pertaining to the experiences and perceptions of that skill.

Transcendental Phenomenology

Transcendental phenomenology is the process in which a researcher explores a research phenomenon through a fresh, open-minded perspective (Moerer-Urdahl & Creswell, 2004). Data analysis begins as soon as data is transcribed from the first interview (Moerer-Urdahl & Creswell, 2004). This phenomenology approach utilizes bracketing, transcendental-phenomenology reduction, and imaginative variation to synthesize the essence of the experience (Moerer-Urdahl & Creswell, 2004). To define the essence of this study, this researcher bracketed her own experiences with foster care children and foster care alumni, identified significant statements given by research participants, and clustered these statements into units of meaning and themes (Moerer-Urdahl & Creswell, 2004). This created a qualitative codebook, which depicts the clustered statements and emerging themes found in this study.

Bracketing occurs throughout the analytical process and began before the research study was conducted; it suppresses predispositions and prejudices (Moerer-Urdahl & Creswell, 2004). This method was conducted by the researcher and was her consideration of her biases and preconceived notations regarding the phenomena (Moerer-Urdahl & Creswell, 2004). This researcher developed these considerations into brackets (Moerer-Urdahl & Creswell, 2004). Quotes within the qualitative codebook were used to refute the bias that was illustrated in the researcher's brackets.

Reliability

Data analysis began as soon as data was transcribed from the first interview. All interviews were digitally audio recorded to preserve the language and the context of statements and vocal inflections. The researcher transcribed the interviews with the assistance of Verbatim Transcription Services software. Each research participant met with the researcher for 30-60 minutes depending on the depth of information given and the pacing in which the research participant can interpret each question. Transcendental Phenomenology Data Analysis and Hand scoring was utilized to analyze the phenomenological data. This researcher used bracketing, memos, and member checking to give credibility to the research findings of this study. Participants were invited to schedule a second interview to review the transcription from the first interview and to address any discrepancies. The second interview was to ensure member checking, or in other words, to guarantee the accuracy of the transcription.

Sample

Demographic information was gathered for all 5 research participants in this study, 4 of them were female and 1 was male. Four research participants were 26 years of age and 1 participant was 25. Four of these participants were African American and 1 participant was African American and European. Two research participants were in heterosexual marriages and 3 participants had never been married. One research participant had a high school diploma, 1 participant did not complete high school, and 3 research participants did not complete their college education. Four participants did not return to foster care after being terminated from care. These participants spent between 18 months and 11 years in foster care. An additional participant returned to foster care once after being terminated. This participant spent 2 years in

foster care and then another 6 years. Research participants in this study resided in various types

of foster care settings, some individuals resided in a combination of these settings. These

settings include single-family foster care homes with foster parents, residing with relatives,

group homes, and residential facilities.   These participants entered care between 3 and 15 years

of age and exited care between 7 and 19 years of age. After foster care, 2 participants were

adopted and resided with their adoptive parents, 1 participant returned to their biological parents,

another resided with a biological relative for a brief period of time before residing by themselves,

and an additional participant was immediately able to reside by themselves. Four out of the 5

participants reported a current need for public assistance to meet their basic needs. Three of the

research participants were employment full-time, 1 participant was unemployed due to a recent

relocation and another participant was unemployed awaiting the start of her college education.

Pseudonyms were assigned to each research participant to maintain their confidentiality.

Results

Sufficient life skills attainment means that an individual can address multiple facets of

each life skill without facing negative consequences, such as poverty, school withdrawal,

substance abuse, generational foster care, incarceration, unintended pregnancies, and early death.

Multiple research participants noted that they were not exposed to or had very limited exposure

to the life skills addressed in this study. These participants noted that they utilized trial and error

and crash courses to make improvements in various life skills. These responses were more

common when discussing factors related to work, housing, money management, and career and

education planning skills. Bonnie stated, "…the work thing, you know, we were basically on our

own…" Danielle noted that she began adulthood with a negative credit report due to some

family expenses that were charged to her as a child. She reported that she had limited support in

addressing this concern and continues to have difficulty in this area. She stated, "My credit is messed up. I don't know how to fix that yet. I'm probably going to file bankruptcy." Fiona reported, "I got my first phone and my first bank account when I was in the 8th grade, but I didn't save enough like I was supposed to. I didn't manage it right." Julia spoke to this issue the most. She noted she was limited in her ability to perform home cleanliness, food and nutrition, budgeting, banking, and transportation related skills. This research participant also noted that her sex education training was limited to conversations regarding what to refrain from. Julia made the following statements during her interview:

"…They had people to clean our rooms for us. We were not allowed to cook our own meals… some people were like coming of age and, of course, like they had those talks with us but the talks pretty much went 'don't do this'… I don't feel like they fully explained why we should or should not do something… They [gave] us pretty much crash courses in things… I can't honestly say that there was any improvement as far as money because pretty much what I wanted for Christmas, they got for me. Of course, they would put money, you know, in our accounts and you know we could spend it until it was gone and, eventually, we would get more… I never learned how to drive until after foster care…I felt like a lot of that was trial and error."

There were other phenomena that were noted as a lack of support in attaining life skills training, but are less directly correlated with the efforts of life skills training due to the possibility of additional factors such as perceived age-appropriate behavior, residuals of previous trauma or pre-placement care, and a lack of preparedness for life skills development. Bonnie noted that between 17 and 20 years of age, she began partying and was unable to complete her post-secondary education plans. She noted, "You somehow get side-tracked and go in a whole new direction… this was like any other person at that age, they change their minds…" Julia

reported some difficulty with relationship and communication skills which derived from her difficulties trusting others. It is not unlikely that the factors that lead to this participant being removed from her biological family had a contributing impact on her ability to feel trusting of others. This research participant stated, "My husband and I, when we were dating, it was really hard because he came from a well put-together home, mother, father, and everything… I had trust issues but he was always willing to trust…" Danielle reported, "I feel like it should have been better opportunities as far as [school]… I knew I wanted to go to school and all that but I never really stuck with anything and I had no idea of what I wanted to – you know really go to school for."

Discussion

This study acknowledged that the depth of life skills training has a major influence on the experience of obtaining life skills while in foster care. This finding was multi-faceted in the sense that it encompasses the foster care graduate's perceptions of the amount of support their life skills trainers offered them, their lists of other supports in obtaining life skills, and their lag in obtaining adequate life skills training after having a period of misguidance during childhood. Casey Life Skills (2016), Alabama Department of Human Resources (2016), and foster care expert Sarah Gilbert (personal communication, December 28, 2016) indicated that foster children may be limited in the amount of life skills exposure they receive due to the type of residence they reside in, ambiguity of life skills training in the ISP, and the lack of consistency in how direct childcare workers and social workers measure life skills attainment.

As adults, foster care graduates no longer have a social worker to provide support and guidance while they navigate family relationships and mentorships. Four of the five participants in this

study reunified with at least one biological relative after foster care. This can be correlated with their reports of a lack of depth to their life skills training and their continued need for life skills training as adults.

Conclusion

Foster care youth are often burdened with factors that may have an impact on their aptitude for life skills attainment, such as mental illness, low or borderline intellectual functioning, and environmental factors such as a history of school truancy, substance exposure, community violence, homelessness, and poverty. These factors and insufficient depth to life skills training are thought to be huge contributors to the dismal outcomes for foster care graduates. It is concerning that the research participants of this study felt powerless to resolve the outcomes of future foster care graduates as advocates, social workers, judges, foster parents, or law makers. As counselors, we must educate ourselves about the child welfare system and the intricacies of belonging to this group. Then, we must learn how to identify our clients who are foster care graduates and individuals who are directly impacted by foster care graduates, such as their parents, children, siblings, and others depending on the counseling relationship. Finally, we must demonstrate empathy when creating our treatment goals, measure what is thought to be an achievable goal for each foster care graduate and assist foster care graduates in their life skills attainment. This is necessary because clients who understand the relationship between their life skills attainment and their current level of functioning are at an advantage to seek assistance, abandon poor habits, and learn more effective approaches to their issues (Hodge et al., 2012).

An additional resource for life skills development are Family and Consumer Sciences (FCS) courses. FCS is the study of human development, personal and family finance, housing

and interior design, food science, nutrition, wellness, textiles and apparel, and consumer issues (American Association of Family and Consumer Sciences, 2015). It can be attended by foster care children and children residing with biological and adoptive parents (American Association of Family and Consumer Sciences, 2015). FCS was previously known as Home Economics. It not only serves as an opportunity for life skills development, but also as a gateway to career technical education in careers, such as interior design, culinary arts, cosmetology, and fashion designing (American Association of Family and Consumer Sciences, 2015). It is taught in federally funded junior and high schools across America. FCS was previously known as Home Economics. It not only serves as an opportunity for life skills development, but also as a gateway to some employment options.

Researchers should also study the impact of the ILP program and future statewide affiliation with Foster Care Alumni organization or similar organizations. An alternative to ILP might be Family and Consumer Sciences. It is taught in junior high and high schools across the United States (American Association of Family and Consumer Sciences, 2015). Future research should examine the effectiveness of highly qualified Family and Consumer Science programs on life skills attainment. These programs would include a curriculum, skilled instructors, related activities, and assessments. With better understanding of these factors, it is possible to better understand the lived experiences and the needs of foster care graduates. Then, those negative outcomes can be challenged with new approaches that are presumed to have the greatest impact on the self-sufficiency of foster care graduates.

Reference

Alabama Department of Human Resources. (2016). Child abuse FAQS. Retrieved from

http://dhr.alabama.gov/services/Child_Protective_Services/FAQs_CA.aspx

American Association of Family and Consumer Sciences (2015). Home Page: Retrieved from

http://www.aafcs.org/home

Barnow, B. S., Buck, A., O'Brien, K., Pecora, P., Ellis, M. L., & Steiner, E. (2013). Effective

services for improving education and employment outcomes for children and alumni of

foster care service: Correlates and educational and employment outcomes. Child and

Family Social Work 2015, 20, 159-170. doi: 10.1111/cfs.12063

Casey Family Programs. (2016). Resources: Casey life skills. Retrieved from

www.casey.org/caseylife-skills-resources/

Chapman, M. V., Wall, A., & Barth, R. P. (2004). Children's voices: The perceptions of children

in foster care. American Journal of Orthopsychiatry, 74(3), 293–304. doi:

10.1037/00029432.74.3.293

Courtney, M.E., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011). Midwest

evaluation of adult functioning of former foster youth outcomes at age 26. Chicago, IL:

Chaplin Hall at the University of Chicago

Department of Social Services. (2016). Foster care services. Retrieved from

https://dss.sc.gov/content/customers/protection/fcs/index.aspx

Katz, D. (2011). Holistic medicine: How to define it. The Huffington Post. Retrieved from

http://www.huffingtonpost.com/david-katz-md/holism-helicopters-spiral_b_828643.html

Keller, T. E., Cusick, G. R., & Courtney, M. E. (2007). Approaching the transition to adulthood:

Distinctive profiles of adolescents aging out of the child welfare system. Social Service

Review, 81(3), 453–484. doi: 0037-7961/2007/8103-0004

Moerer-Urdahl, T., & Creswell, J. (2004). Using transcendental phenomenology to explore the

"ripple effect" in a leadership mentoring program. International Journal of Qualitative

Methods, 3(2).

U. S. Department of Health and Human Services. (2016). Mandatory reporters of child abuse and

neglect. Retrieved from https://www.childwelfare.gov/pubPDFs/manda.pdf

Counselor competence with male body image disturbance

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Abstract

There are significant cultural pressures existing in modern Western society for individuals to fit into an idealized shape or appearance (Gillen 2006). The cultural pressures can come from a variety of sources from the media, peers, family, role models, and many others. This article seeks to provide strategies for counselors to treat males struggling with body image disturbance through narrative therapy.

Counselor competence with male body image disturbance

There are significant cultural pressures existing in modern Western society for individuals to fit into an idealized shape or appearance (Gillen 2006). The cultural pressures can come from a variety of sources from the media, peers, family, role models, and many others. The cultural pressures from mass media can come in a plethora of forms from TV, movies, print media, etc. There have been numerous studies on the negative impact that the media is having on the body image of men (Botta, 2003; Olivardia, Mulgrew, Volcevski-Kostas, & Rendell, 2013; Pope, & Hudson, 2000). Peers and family can also be a source of cultural pressure to conform to an idealized body shape or appearance, as they are an important forum of feedback for all individuals in our society. The last source mentioned, role models, can come in the form of TV/movie stars, teachers, authority figures, etc. These individuals are passing along to other people their own body images values in the clothes the physical appearance they advocate through their actions.

The aforementioned sources can make a particular impact on college-age males. This is of particular interest in the reflection on the impact of Western culture on the body image of individuals in our society today. College-age males are typically deeply engaged in theorist Erik Erickson's developmental stage of Identity versus Role confusion during this time (Berk 2008). While the typical age range for this developmental state is 13-19 years of age, It is theorized that the age range can be lengthened to include the early 20's. This stage of development is typically characterized by individuals making a transition from the relative safety of childhood into the challenging world of adulthood. During this transition time, adolescents are exposed to experiences that cause them to consider their role in the "real world". College-age males are forced to consider who they are as individuals and how they can fit into their society, both

locally and as a member of a global community. Initially, many men tend to experience confusion and frustration as they consider their changing roles in nearly every aspect of their lives, such as roles within the family, academically, occupational, and transition towards self-sufficiency. This confusion and frustration, as it relates to college-age males, can come in the form of misconceived notions of what it means to be man in Western society today leading to many different behaviors either conforming or resisting their perception of the messages being received (Berk 2008). A part of this desire to conform can take the form of trying to "fit in" to what society says is preferable is to strive for the idealized body image promoted by Western culture.

While there have been previous studies on female college students and their high prevalence of body image problems, such as body dissatisfaction and difficulty maintaining dieting practices (Gillen, 2006), men's body image is becoming an increasingly growing problem. College-age men have been increasingly exposed to an idealized body image that can prove to be difficult for many to achieve. Gillen states it well when he quotes Leit, Pope and Gray 2001, "Although less is known about men's body image, cultural trends toward a muscular ideal for men suggest that body image may increasingly become a salient issue for them as well" (p. 25). Olson (2009) supports this theory of a cultural impact on male body image when she writes on how some recent studies have shown that men who participate in activities or sports that are more focused on their appearance or physical condition, such as body-building, wrestling or modeling, have been found to exhibit "non-normative pre-occupations" with the size and shape of their bodies (Olson , 2009, p. 46).

Gillen 2006 states it well again when he discusses how in studies of college students' body image it is important to understand the context of the students' experiences with messages

on an ideal body image. Gillen writes that freshmen student's evaluation of how he, in this case, should appear comes from the various physical, social, and emotional changes he is experiencing as a result of entering this new state of life. These men are experiencing a community surrounded by peers in all parts of their life, including residence halls, classes, social activities, and work environments. Gillen theorizes that this exposure in multiple parts of an adolescent male's life may have a significant impact on student's body attitudes. Moreover, being in the peer-dominated environment that typical undergraduate college life creates, may increase the likelihood of college-age males to make appearance comparisons to their male peers, or maybe even heighten self-consciousness due to the presence of potential dating partners, either male or female. Also Gillen states that involvement in campus organizations or activities that encourage the importance of attractiveness, such as voting for homecoming king/queen or fashion clubs, may promote detrimental changes in body image for some college-age males. Due to the inherent group-think about the values of appearance, male students in these organizations may be more focused to their looks and may continually evaluate how they measure up to cultural or group-specific beauty standard.

Theory and Application

One way in which we as counselor educators can help combat the growing problem of male body image issues appearing in counseling sessions, is to equip our students with the tools to help these men in need. One technique for helping counseling students address this issue is narrative therapy. Leahly and Harrigan 2006 define narrative therapy very well, "Narrative therapy is a form of therapeutic intervention underpinned by a philosophy of language proposing that meaning is socially constructed through language." (480) The authors go on to state how power relations, social contexts and personal contexts are considered to be essential to the

creation of meaning for the individual. Narrative therapy is a therapeutic approach based on the assumption that people experience problems, or difficulties, in their lives when the social stories, or ways of understanding, that the predominant society has impressed upon them do not accurately represent their lived experience.

Narrative therapy can be helpful in counseling body image disturbed college-age males in that it offers a forum in which these individuals can "re-write" the problematic learned life stories in their lives and relationships into something more in-line with a healthier state of mind (481). Along with re-writing the learned life stories, effective counselors can also help clients make meaning of non-storied events in their lives. These "un-storied events" may be going unnoticed, ignored, unspoken, or even discarded because the client is not aware of the importance of these events in their life. Narrative therapy assumes that these discarded narratives offer alternative interpretations of experience. Therefore, life stories that hinder the individual or carry negative messages can be re-written by creating alternative, more empowering self-authored stories that include previously ignored, un-storied events (481).

There are six essential processes to successful narrative therapy; the be relationships, externalizing, deconstruction, unique outcomes, and thickening the plot. The first process, the therapeutic relationship, is essential to any therapeutic intervention. In narrative therapy, the counselor takes on the role of a "co-author" with the client as they re-write existing life stories or create new ones from the client's past experiences. For men struggling with poor body image, the development of a positive therapeutic relationship would be crucial. As with any client, the therapeutic relationship is the foundation of counseling and the first step towards change. In narrative therapy, it is important to establish equality in the relationship and to empower the client to trust the counselor as they begin to tell and reprocess their story.

The second process, externalizing, is typically seen as the first step to empowering clients to take action against a problem or troublesome learned story by encouraging them to take an identify separate from the problem they are facing. Externalizing the conversation away from a male client struggling with body image may help client move the focus away from self-blame and judgment to one of the problem as an external force that is being imposed upon him. In essence, the man is separated from his body image concerns, which makes it easier to address and "re-tell" in the future. This process is very helpful in clients making meaningful progress in dealing with troublesome imposed life stories when they can view problems as an external force they have the power to change or not allow to control them anymore.

The third process, deconstruction, is the process by which, following identifying the problem as an externally imposed story, the counselor helps the client break down the history of the problem within the pre-created external framework. The deconstruction process involves the ability for both the counselor and the client to delve into the client's past. During this part of narrative therapy, the counselor can help the client understand some of the background by how the problem came to be written in the story of his life. Often, knowing how the problem came to ingrain itself into his's life helps the male client with body image concerns to better understand it and eliminate it from his's life.

The next process, unique outcomes, involves identifying events that contradict the dominant, problem-saturated externally imposed story. This part of narrative therapy is based on the assumption that the problem has sometimes been resolved successfully, at least in some small part, in the past. This part of the process can be explored as the male client with body image issues shares his story and the counselor looks for times where the client has a higher level of body image.

The last process, thickening the plot, involves helping the client further strengthen the newly developed life story by performing or telling new stories before an audience of others known to the client. The audience can help to validate the client's new story and encourage him to consider the new story as a viable plan of action. This last part of the process can be done through a spoken presentation, completion of a creative project, or a certificate of completion. Ending the therapeutic process with a tangible item is beneficial for clients of all ages and serves as reminder of the process the client has made.

References

Berk, L. E. (2008). *Infants, children, and adolescents* (6th ed.). Illinois State University: Allyn & Bacon.

Botta, R. A. (2003). For your health? The relationship between magazine reading and adolescents' body image and eating disturbances. *Sex Roles*, *48*, 389– 399. doi: 10.1023/A:1023570326812

Gillen, M. & Lelfowitz, E. (2006). Gender Role Development and Body Image among Male and Female First Year College Students. *Sex Roles*. 55:25–37.

Leahly, T. (2006). Using Narrative Therapy in Sport Psychology Practice: Application to a Psychoeducational Body Image Program. *The Sport Psychologist*. 20: 480-494.

Mulgrew, K. E., Volcevski-Kostas, D., & Rendell, P. G. (2013). The effect of music video clips on adolescent boys' body image, mood, and schema activation. *Journal of Youth and Adolescence*. doi: 10.1007/s10964-013-9932-6

Olivardia, R., Pope, H. G., Jr., & Hudson, J. I. (2000). Muscle dysmorphia in male weightlifters: A case-control study. *The American Journal of Psychiatry*, *157*, 1291– 1296. doi: 10.1176/appi.ajp.157.8.1291

Olson, M., Esco, M., and Williford H. (2009) Body Image Concerns in College-Aged Male Physical Education Students: A Descriptive Inquiry. *Physical Education*. 66 (1), 45–54.

Antisocial Personality and Spirituality

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Abstract

This paper addresses the role of spirituality and treatment when working with individuals having Antisocial Personality Disorder (ASPD). It addresses what Antisocial Personality Disorder is, as well as the genetic and neurological aspects of this disorder. It defines the role of religion and spirituality as related to ASPD and the role of the chaplain in the prison system. It also addresses both secular and spiritual treatment for people diagnosed with this disorder.

Porter (nd) describes people with Antisocial Personality Disorder (ASPD) as people that habitually violate the rights of others without remorse. People with ASPD either violate the law, engage in criminal behavior, or manipulate or hurt others in ways that are unethical, immoral, irresponsible and violate social norms. People having ASPD have defective moral consciousness and make decisions to benefit themselves without consideration of how their behavior impacts others. People having ASPD often engage in impulsive behaviors, as well as criminal behavior.

ASPD can have both a genetic or environmental genesis. The term ASPD is defined as being against societal rules, norms, laws, and acceptable behavior. They often are likeable, charming, and can gain the sympathy of others. They often have above average intelligence. They can be thoughtful and cunning, are able to analyze others, determine the needs of others, and use that information to manipulate and exploit others without guilt, shame, remorse, or regret. They may use empathy to gain pleasure from the pain they cause victims. Although people with ASPD do have empathy, they are able to interrupt it to exploit his or her victims (Porter, nd).

Official symptoms according to the DSM-5 (2013) include disregard for and violation of other's rights since the age of 15 as evidenced by failure to obey laws and engaging in criminal behavior, lying, deceiving and manipulating others for profit and amusement, impulsivity, irritability and aggression, assaultive behavior and fighting, irresponsibility, and lack of remorse. The person must be at least 18 years old. Conduct Disorder was present before age 15, the behavior must not be associated with a Major Mental Illness.

Risk factors, according to Porter (nd), include being male and having a first degree relative with ASPD. There is a theory that the person is born without a conscience. There has been evidence that people diagnosed with ASPD have difference in the frontal and parietal lobes which are associated with attention, self-regulation, impulsivity, and difficulty resolving conflicts. Impairment in the cerebellum may be associated with low arousal, impulsivity, lack of conscience, lack of empathy, and poor decision making. Environmental factors associated with ASPD is the person's receiving the message from parents and peers that antisocial behavior is acceptable. Co-morbid disorders associated with ASPD include Oppositional Defiant Disorder, Reactive Attachment Disorder, and Conduct Disorder which is often a precursor of ASPD. Other co-morbid disorders are substance abuse and other personality disorders.

Porter (nd) purports that people with ASPD may experience incarceration, premature death from violence and accidents, and loss of assets from over-spending. Relationships often end in divorce or separation. They may be estranged from family and others due to financially exploiting others, stealing from others, emotional abuse of others, physical and sexual assaults, and homicide. Social and psychological disorders are elevated in people with ASPD including homelessness, anxiety, depression, and suicidality.

Patrick (2018) contends that social predators target people due to his or her weakness and vulnerability. They often pick victims based on perceived lack of credibility based on background, social status, criminal record, or other vulnerability. They may use flattery and positive attention toward those that will help him or her get ahead. They may violate the law or violate loyalty by exploiting victims financially, by ruining their reputation, emotional abuse and sometimes, sexual abuse.

Patrick (2018) reports one of the most dangerous parts of ASPD in people that do not engage in criminal behavior is that their predatory behavior may go unreported and undetected. They exploit victim's emotions and resources. They often do not care how their behavior affects others which enables them to break promises, reveal private information, and take credit for other people's accomplishments.

People with ASPD may groom victims by breaching boundaries while developing a sense of trust in the victim while, at the same time, exploiting the victim for sex, money, power, or the enjoyment of inflicting harm. People with ASPD may seek out positions to mentor and as role models for youth and new hires to produce a power imbalance to isolate and potentially exploit victims. The predator may play with a victim's emotions leaving the victim feeling exploited and humiliated but unsure if he or she has been victimized.

Neo, Sellbom, Smith, and Lilienfeld (2018) indicates that sociopaths may remain bold and calm in threatening situations and recover quickly from stress. They may be socially dominant and persuasive. They can be mean and deceitful and show a lack of moral compass. People in supervisory positions may lie, steal, and threaten employees. They may also rise to leadership positions in an organization due to their superficial charm.

Passive management indicates a manager that acts only to employees' mistakes and is often a lazy leader. Psychopathy is associated with this type of leadership. Meanness inhibits team building and ethical decision making and enhances inappropriate supervisory tactics (Sellbom, Smith, & Lilienfeld, 2018). The DSM-V (2013) indicates that people diagnosed with ASPD may show a decrease in sociopathic behavior in their 40's due to weariness of fighting

societal norms, as well as the effects of substance abuse and physical illness and injury. However, the criminal thinking continues.

Environmental Influence of Antisocial Personality Disorder

Tuvblad and Beaver (2011) contend that environmental influence may be adhering to antisocial norms of one's peer group, as is relational aggression. Negative environmental influence may also be indicated by hostile relationships with one's parents from an early age. People having ASPD tend to respond to moral dilemmas utilizing a utilitarian response, rather than a moral response. Utilizing a utilitarian response when making moral decisions does not elicit anxiety in this population. Environmental factors related to ASPD include extreme poverty, sociopathic peers, and poor parenting.

Genetic Components of Antisocial Personality Disorder

Baker, Bezdijian, and Raine (2008) contend that the genetic components of ASPD are evidence by three sources. The first is that aggression and criminality have genetic components as evidence by such behavior occurring in related individuals as compared to others in the environment. Second, impulsivity, sensation-seeking, risk taking, and unemotional traits are genetically derived. Third, ASPD is associated with gambling and substance abuse which are evidenced to have a biological and genetic component. Biological risk factors include abnormality in neurotransmitters, low physiological arousal, hormonal abnormality and impaired frontal lobe functioning.

Those that demonstrate life long criminal behavior are more likely to have a genetic component related to ASPD than those that start at a later age. Antisocial behavior among adopted people increased when a biological parent was convicted. Genetic components in

ASPD have also been evidenced in twin studies. Conduct Disorder, which is a childhood precursor of ASPD is associated with depression, anxiety, substance abuse and ASPD. ASPD in a parent is the strongest predictor of Conduct Disorder in children (Baker, Besijidian, & Raine, 2008).

ASPD shows co-morbidity in Attention Deficit Hyperactivity Disorder (ADHD) and aggressive behavior in children. Aggressive behavior, impulsivity, substance abuse, irritability, and neurological disorders can be inherited. Children with ADHD present with worse symptoms of conduct disorder and antisocial behavior, including more physical aggression (Baker, Besijidian, & Raine, 2008).

Neurological Components of ASPD

Baker, Besijidian, and Raine (2008) reports that serotonin and dopamine are implicated to ASPD, both of which are susceptible to environmental factors. Sofi, Fisher, Hjordt, Perfalk and Beliveau (2018) contend that serotonin regulates emotional processing and control and is associated with depression, anxiety, and aggression. Serotonin originates in the brain stem and low levels of serotonin is associated with aggression in humans and animals. Aggression and murder has been associated with reduced orbitofrontal cortex, an area of the brain that is associated with reduced fear, personality and emotional impairment indicating a relationship between neurological impairment associated with violence and antisocial behavior. Anonymous (2018) published an article in Psychology and Psychiatry Journal about neurobiological findings in psychopathy and altruism that indicates that the dopamine reward system affects the brain based on personal and cultural experience to determine where the person will perform on the spectrum between altruism and sociopathy.

Religion and Spirituality in ASPD

Holmes and Kim-Spoon (2017) purport that religion affects antisocial behavior only when religion is the societal norm. If the person is more engaged in secular society, religion has little impact on antisocial behavior. Therefore, social environment was the mitigating factor that impacted antisocial behavior. Holmes and Kim-Spoon indicate that the belief in a Divine being that provides oversight was a mitigating factor to antisocial acting out. Religion and spirituality provided purpose, identity, and a moral compass. Additionally, Holmes and Kim-Spoon found that children that had less religion and spirituality than their parents were more likely to act out against others and show antisocial behavior.

Clear, Stout, Dammer, Kelly, Hardyman, and Shapiro (1992) reports that prisons in the United States were founded by religious leaders. Religion continues to be one of the most prevalent areas of programming in prison. Courts have protected religious practices for prisoners. Prisons contrast from religion. Prisons are bad and you are there to be punished because you are a social outcast. Religion is about good things.

It is believed that a person adjusts to prison if he or she can cope without feeling threatened, anxious, or upset and if the person does not get into trouble in the system. Religion is believed to assist inmates in dealing with the emotional strains and deprivation of being in the prison environment. Religion helps inmates deal with guilt, depression, and self-contempt. It gives inmates a sense of direction about how to live his or her life. Religion can also give inmates a sense of freedom from the pressure of incarceration (Clear, Stout, Dammer, Kelly, Hardyman, & Shapiro (1992).

Religion helps inmates cope with a sense of loss. Inmates experience a lack of safety, a lack of material comfort, and a lack of intimacy. The chapel can provide sanctuary for inmates that are vulnerable to more powerful inmates. Involvement in the church can provide material privileges that are not readily available to other inmates, including extra phone calls, postage, gatherings with snacks, relief from being in the cell or dorms, and free-world visitors. Inmates that participate in religious activities in the church present as more optimistic than other inmates (Clear, Stout, Damme, Kelly, Hardyman, & Shapiro, 1992).

Clear, Stout, Damme, Kelly, Hardyman, and Shapiro (1992) report that inmate's participation in religion parallels that of people in the free-world. Religion makes life more comfortable. Religion provides emotional support. It provides environmental support to avoid conflicts inherent in the prison system. On one hand, the inmate may be pursuing religion to be more insightful and to feel closer to a Higher Power. On the other hand, the inmate be pursuing religion for extrinsic reasons because he or she get extra benefits, including access to other people, food at, and after meetings, and the opportunity to meet women or men from the outside (Aten, O'Grady, & Worthington, 2012).

Role of the Chaplain in Prison

Denny (2017) indicates that prison chaplains, typically, perceive issues that confront prison and inmates include criminal thinking, lack of community support, and an impaired sense of morality. This history of the word penitentiary comes from the word penance and the early belief that the only deterrent to crime for inmates was to embrace religion. The courts protect the religious rights of inmates and prison chaplains are given the job of administering and organizing religious programs, but often leaves little room for prison chaplains to provide religious services.

Research among prison chaplains indicate that they perceive the most important issues facing incarcerated individuals include substance abuse and mental health, religious program in prison, and religious support after release from prison. Prison chaplains acknowledge social, psychological and medical issues, along with religious issues, including poor social support and poor impulse control. Prison chaplains must interact with inmates of all religious beliefs, and not just the chaplain's faith. Religion in prison provides a way to resist criminality, provides a moral compass, provides an opportunity to practice emotional control, and provides social support that is not abundant in corrections. The chaplain can act as a bridge between the religious community in prison and the religious community in the free-world, reducing anxiety and stress due to re-integration into the community, thereby making re-integration into the community smoother.

Secular Treatment for ASPD

Most clinicians indicate that there is little effective treatment for ASPD. However, that belief has started to be challenged. Porter (2018) indicates that people diagnosed with ASPD do have some degree of empathy, but they use it inappropriately to manipulate his or her victims and can turn his or her empathy off at will. Since people with ASPD do have some degree of empathy, he or she may be able to be trained to use that empathy more appropriately. DSM-5 (2013) indicates treatment that may be helpful in ASPD includes Cognitive Behavioral Therapy and Cognitive Self Change.

Sofi, Fisher, Hjordt, Peralk, and Beliveau (2018) indicates treatment that addresses aggressive behavior and impulse control. Some of that treatment may include medication to balance serotonin and dopamine levels. Another treatment may be anger management.

Additional treatment may include addictive behavior including treatment for gambling, sex offender treatment if necessary, and making good decisions. Communication skills and Domestic Violence may be helpful, as well as learning to respect animals since there is a connection between animal abuse and abuse of humans and many people diagnosed with ASPD begin by harming animals before they progress to harming people.

Spiritual Treatment for People Diagnosed with ASPD

The DSM-5 indicates that there are some instances of people converting to religion which helps him or her to change his or her thinking and re-integrate into society. Denney (2017() purports that participation in prison ministry deters criminal thinking, provides moral direction, helps to control emotional dysregulation, and provides social support. It also gives inmates a way to normalize prison life in a healthy way by providing socialization and allowing access to people outside of the prison setting. Prison ministry can also serve as a bridge to religious institutions upon release from prison which cuts down on anxiety and stress while re-integrating into the community. Prison ministry helps to decrease depression, anxiety, suicidality, improves self-concept, and allows the inmate to cope with his or her sense of loss.

Summary

This paper explains the symptoms of Antisocial Personality Disorder (ASPD) and the consequences to the individual that has this disorder and the impact of this disorder with those with whom the individual with the diagnosis comes in contact. The origin of this disorder has both a genetic and neurological component. There is also an environmental component to this disorder. Everybody that is diagnosed with ASPD does not necessarily wind up incarcerated, but

everybody with this diagnosis creates problems for others due to his or her lack of empathy and willingness to exploit and harm others.

There is a genetic component of ASPD evidenced by it running in families. There is also an environmental component to ASPD which is evidenced by people that begin acting out at a later age than children that begin showing criminal, behavioral, and mental health symptoms in earlier childhood. There is a neurological component to ASPD effecting both the serotonin and dopamine systems which affects the frontal lobes and the limbic system, especially the amygdala.

The religious role of prison allows people to address his or her criminal thinking, provide emotional support, and provide a haven from a stressful, dangerous, and hostile prison setting. The role of the prison chaplain is to administer prison programs. Prison chaplains can be a conduit for inmates transitioning from prison back into the community by linking the inmate to community religious resources.

Secular treatment incudes empathy training, Cognitive Behavioral Therapy and Cognitive Self-Change, medication to regulate brain chemicals which would then, hopefully, reduce impulsivity and aggression. Treatment would address addictive behavior, sex offenses when appropriate, domestic violence, and respect for people and animals. Spiritual treatment would include participation in spiritual or religious activities, coming to terms with one's criminal thinking and behavior, one's loss of freedom, loss of self-esteem, depression, and suicidality. Spiritual participation can provide a moral compass for inmates, provide a safe place to keep them safe in a hostile environment, and assist with re-entry into the community by providing a

bridge between prison ministry and ministry in the community if the person is pursuing religion

for intrinsic purposes

References

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5th ed).* Washington, DC: American Psychiatric Publishing.

Anonymous (2018). Neurobiology: New neurobiology findings from the University of Central Florida described (Psychopathology to altruism: Neurobiology of the selfish-selfless spectrum. *Psychology and Psychiatry Journal: (Atlanta),* 19May2018: 3533.

Baker, L. A., Bezidjian, S. & Raine, A. (2008). Behavioral genetics; the science of antisocial behavior. Retrieved from https://scholarship. Law.duke.edu.

Clear, T. R., Hardyman, P. L., Stout, B. D., Dammer, H. R., Kelly, L., & Shapiro, C. (1992). *Does involvement in religion help prisoners adjust to prison?* Retrieved from: https://www.ncjrs.gov.

Denny, A. S. (2017). Prison chaplains: Perception of criminality, effective prison programming characteristics, and the role of religion in the desistance from crime. *American Journal of Criminal Justice.* Louisville (Nov 2017: 1-30.

Neo, B., Sellbom, M., Smith, S. F., & Lilienfeld, S. O. (2018). Of boldness and badness: Insights into workplace malfeasance from a triarchic psychopathy model perspective. *Law of Contemporary Problems, 69*(1-2): 7-46.

Patrick, W. L. (2018). The stealthiest predator. *Psychology Today, 51*(3): 80.

Porter, D. (2018). *Antisocial personality disorder.* Retrieved from https://www.theravive.com.

Sofi, C., Fisher, P. M., Hjodt, L. V. Perfalk, E., Beliveau, V, et al. (2018). Men with high serotonin 1B receptor binding respond to provocations with heightened amygdala reactivity. *Neuroimage, 16* (Feb 1, 2018): 79-85.

Tuvblad, C. & Beaver, K. M. (2013). Genetic and environmental influences on antisocial

behavior. *Journal of Criminal Justice, 41*5): 273-276.

Counselor Education and addressing the needs of the LGBT community: Are we doing enough?

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Abstract

Counselor education programs aim to equip counselors in training with skills essential to effectively treat clients of all races, ethnicities, and cultures. The American Counseling Association (ACA) has stressed the importance for counselors in training to demonstrate multicultural counseling competence through the development of ethical guidelines and standards for counselor education programs to incorporate into their curriculum (American Counseling Association[ACA], 2005; Kağnici, 2014; Powell & Benshoff, 2008). While these courses lay the groundwork for cultural competence in counseling, they do not fully prepare counselors to effectively counsel clients who identify as a sexual minority. The current article highlights the need for counselor education programs to enhance curriculum and incorporate specific training techniques to better serve individuals who are Lesbian, Gay, Bisexual, and Transgender (LGBT).

Counselor Education and the addressing the needs of the LGBT community: Are we doing enough?

Many professions including counseling are influenced by social justice issues. The question remains, are we as counselors and counselor educators reaching our full potential in relation to addressing social justice issues, and adequately preparing beginner counselors to effectively treat those impacted? Chang, Crethar, and Ratts (2010) discussed their views on the relationship between counseling and social justice, in addition to being interdependent on one another they are imperative to helping clients reach their goals.

Social justice counseling is the next wave that falls under the umbrella of multicultural counseling (Chang, Minton, Dixon, Meyers & Sweeny, 2012; Lee, 2007). Henriksen and Trusty (2005) explained the need for counselors to effectively implement fundamental counseling skills, as they need to be culturally aware of their role in a society that is increasingly diverse. It is recommended that counselors who wish to incorporate social justice and advocacy into their professional identity explore the following six areas: life meaning and commitment, personal privilege, nature of oppression, cultural competence, and global literacy (Chang et al., 2012; Lee, 2007). Exploring different aspects related to personal and global views of social justice issues allows counselors to grow in their professional identity as it relates to social justice counseling. As social justice becomes a driving force behind the field of counseling it is worthwhile to discuss the effectiveness of counselor education programs, specifically, the preparation of future counselors to become leaders who can effectively counsel clients from multicultural and minority populations. In order to move forward in the discussion of preparing counselors in training to effectively work with the LGBT population in is important to understand the historical context surrounding this population.

LGBT Oppression

Historically, individuals who identify as lesbian, gay, bisexual, and transgender (LGBT) have been the victims of oppression and discrimination with instances of social and criminal injustices tracing back centuries to the early American colonies (Noga-Styron, Reasons & Peacock, 2012). While the labors of the LGBT community were focused on trying to gain acceptance and equal rights, the community was consistently receiving backlash for their efforts. The AIDS epidemic brought about more attention and awareness as it exposed the discrepancy related to legal protections and allowed for the discussion of LGBT rights (Noga-Styron, Reasons & Peacock, 2012). Jones, Brewster, and Jones (2014) felt similarly and stated, "even though great strides have been made by queer communities and their heterosexual allies regarding equality and the rights of LGBT persons in the United States, such individuals still experience an inordinate amount of victimization, oppression, and discrimination" (p.182). The current article highlights a need for counselor education programs to incorporate specific training techniques, as well as ways to enhance existing curriculums to better prepare counselors in training to effectively serve LGBT clients.

Discrimination of LGBT Individuals

The counseling profession continues to combat discrimination of all minority groups. To align the definition of discrimination in relation to the LGBT population, it would include unfair treatment of a person or group of people based on their sexual expression (Bostwick, Boyd, Hughes, West, & McCabe, 2014; Smith & Okech, 2016). Eliason and Hughes (2004) reminded counselors that while LGBT individuals experience issues specific to their journey throughout life, there are several shared experiences among the LGBT population that should be taken into

account. Some of the shared experiences LGBT populations identify include exploring their sexual identity and sharing their sexual identity with others (Eliason & Hughes, 2004). The idea that distinctive issues bring about diverse experiences for LGBT clients is one that all counselors need to be aware of throughout the counseling relationship.

Bostwick et al. (2014) shared that for those who identify with a marginalized minority, particular stressors such as stigma and discrimination can have an impact on their mental health. In addition, King et. Al. (2008) conducted a meta-analysis focused on suicidality and found that in comparison to their heterosexual counterparts gay and bisexual men are four times as likely to attempt suicide and lesbian and bisexual women are two times as likely to attempt suicide. In addition, the National Gay and Lesbian Task Force (2011) reported, that of the 6,450 transgender individuals they surveyed, 90% experienced harassment or mistreatment at work, 55% lost a job due to bias, 51% had experienced harassment in K-12 education, 61% had experienced physical assault, and 64% had experienced sexual assault. While instances of harassment and discrimination are more easily identified in external situations they can also take place within the counseling relationship.

The term microaggressions can be defined as verbal, behavioral, or environmental ignominies that can be intentional or unintentional which result in offenses toward those who identify with oppressed groups (Nadal, 2008). Shelton and Delgado-Romero (2011) conducted a qualitative study of LGBT clients' experience in counseling and found these clients report they experience bias from their counselors, such as counselors assuming all problems are due to their clients' sexual orientation (Shelton & Delgado-Romero, 2011). According to Helms, Nicolas, and Green (2010), people who repeatedly experience microaggressions may develop trauma

symptoms, as they are reminded of their vulnerability in a society where they are faced with the constant possibility of violence.

Multicultural Competency

The American Counseling Association (ACA) Code of Ethics (2014) defined multicultural or diversity counseling as, "counseling that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness of individuals within their historical, cultural, economic, political, and psychosocial contexts" (p.20). This definition demonstrates that there are several different factors that must be identified and incorporated when counseling multicultural individuals. In order to effectively counsel an individual, it is important to interpret their experiences through the lens by which they view the world. It is also important to understand the individual experiences that a client shares in order to conceptualize the whole client and effectively address their specific needs and concerns. D'Andrea and Heckman (2008) called attention to the multicultural/social justice counseling movement and provide counselors with tools to aid in the development of their competencies when working with multicultural populations. The thoughts on social justice are echoed by Chang, Creather & Ratts (2010), who identified social justice as an inescapable reality in the counseling profession and identifiable at all levels of conceptualizing a client.

In keeping with the theme, multicultural competence for counseling minorities has become a central focus of the counseling field (Watson, Herlihy, & Pierce, 2006). Multicultural or diversity competence is defined by the ACA Code of Ethics as, "counselors' cultural and diversity awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups" (ACA, 2014, p.20). This definition

provided by the ACA clearly outlines counselors' ethical obligations regarding minorities. Watson et al. (2006) elaborated on this by pointing out that as counselor educators our ethical responsibility requires us to strive for competency regarding the many different factors included in multiculturalism. Moreover, in 2004, the ACA Governing Council endorsed a list of counseling competencies, developed by members of AGLBIC, to assist graduate professors and programs in training competent mental health professionals (Logan & Barrett, 2005). The list of 32 competencies is based on the professional literature and research and includes sections related to professional identity, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation (Logan & Barrett, 2005). In order to propel multicultural competency to the forefront of the discussion, it is important that counselors and counselor educators embrace the process and incorporate multicultural issues into the conversation whenever possible.

Ethics and Counselor Education

The ACA Code of Ethics (ACA, 2014) does not differentiate between counselors and counselor educators in relation to ethical standards and practices for the counseling profession (Sells & Hagedorn, 2016; Smith & Okech, 2016). Specifically, Standard F.7.c of the ACA Code of Ethics states that counselor educators have an obligation to aid in the development of future counselors by including multicultural content in all courses (ACA, 2014). On a grander scale, Sells and Hagedorn (2016) identified the counseling profession as the pioneer field to create a path for individuals who value sexuality differently compared to other professionals. Sells and Hagedorn (2016) elaborated on the idea of values by stating that counselors in training need to align their personal and professional values. This alignment of personal and professional values becomes pertinent to the discussion of counseling sexual minorities because, for some counselors in training

a reevaluation of previously held values related to LGBT persons may lead to a better understanding of their own self, as well as the clients they are serving.

The discussion of values as they relate to counselors in training opens the door for a larger question posed by Sells and Hagedorn (2016) as they explored the role of counselor education programs and the ethical application of value differences, which is what role do values held by the counselor impact the therapeutic relationship? If value conflicts arise, it is suggested that faculty step in to provide support and help the student identify a mentor who can help with the navigation and understanding of the internal conflict (Sells & Hagedorn, 2016). It is important that counselors in training are supported by faculty so that they are able to navigate their own biases during their matriculation through the counselor education program. Bidell (2013) pointed out that there is a need to develop specialized skills when working with the LGBT population in order to best serve individuals who identify as part of the minority group.

Sexual Minorities, Mental Health, and Counselor Training

Given that there is an upward trend in the rate that sexual minority clients seek out mental health services, it is inevitable that counselors will come across clients who identify as LGBT (Graham, Carney & Kluck, 2012). Sexual minorities are unique in regard to the experiences they face which include, but are not limited to, prejudice, sociocultural stigmatization, internalized heterosexism, and the perceived need to conceal their sexual minority identity (Eliason & Hughes, 2004; Bostwick et al., 2014; Brewster, Moradi, DeBlaere, and Valez, 2013).

While it is evident that counselors will need to meet the needs of LGBT clients in the field, research has shown (Asta & Vacha-Haase, 2013; Bidell 2013; Graham, Carney& Kluck, 2012) that current counseling and psychology programs may not be adequately preparing

counselors in training to meet the needs of sexual minority groups. Murphy, Rawlings, and Howe (2002) found that 72% of graduate students and practitioners surveyed did not believe that they were adequately prepared during their training to address the specific needs of LGB clients. Further, it was noted that only 10% of the practitioners in their study reported the availability of a graduate course in LGB issues and only about half of those respondents had actually taken the course. Another study focused on counseling students' preparedness found similar results. Participants in Graham et al.'s (2012) study of 234 counseling and counseling psychology students reported mid-range levels of competence. Students reported highest levels of competence in awareness of LGB issues, mid-range competence in knowledge about LGB populations, and lower competence intangible skills for working with LGB clients.

Bidell (2013) conducted a study on 23 masters level students enrolled in an LGBT counseling course and found that not only could a course specific to counseling LGBT individuals be beneficial to counselors in training, but it could also lead to greater counselor competency and self-efficacy as a whole. Moreover, there is a need for more effective training models for beginner counselors in order to develop competency in the area of LGBT counseling (Bidell, 2013). Rees-Turyun (2007) shared that the work of counselor education programs to increase the competency of future counselors does not end with implementing effective training models; training programs as a whole need to be committed to supporting LGBT affirmative practices throughout their respective departments.

Multicultural counseling courses have become more commonplace in counselor education programs than in previous years (Bidell, 2013). Although counseling departments and counselor educators recognize the need for greater competency in the realm of multicultural counseling, the addition of one multicultural counseling course to the curriculum is barely

scratching the surface of meeting that need. The question remains, how do counselor education programs meet the needs of counselors in training and successfully prepare them to work with sexual minority clients? Research in the field shows that while having an LGBT affirmative attitude is beneficial when working with LGBT individuals, there is no correlation between affirmative attitudes and counselor competency (Bidell, 2013; Rock, Carlson, & McGeorge, 2010).

According to Ida (2007), one reason counselor education programs face challenges when preparing counselors in training is that the methods by which future counselors are trained are formulated around dated schools of thought, and often neglect to consider the levels of stigmatization that LGBT clients face. While counselor education programs implement specific courses designed to navigate the diverse needs of the LGBT population, we must understand that a change of this magnitude to the curriculum could take years to properly develop and implement (Biaggio, Orchard, Larson, Petrino, & Mihara, 2003). Biaggio et al. (2003) recognized these challenges and provided more realistic ways to implement education techniques specific to the LGBT population and proposed several ways to incorporate LGBT competency into existing curriculum. Some suggestions include: incorporating LGBT specific information and needs into coursework, stress continued education regarding LGBT populations for faculty member, encourage and support research surrounding the LGBT population, recruit faculty with specific interests and expertise in this area, and identify self-awareness in relation to LGBT issues a requirement (Biaggio et al., 2003).

Becoming an Ally

It is not just counselor education programs that are noticing a need for greater competency regarding counseling multicultural clients. Nearly 20 years ago, ACA identified a need for more emphasis to be placed on the specific needs of the LGBT population (Graham, Carney, & Kluck, 2012). These needs were related directly to areas such as mental health concerns, effective interventions, correct terminology, accurate information regarding sexual orientation. While this is not an exhaustive list Graham, Carney, and Kluck (2012) agree with the ACA's position on the matter. The development of skills specific to the LGBT population can aid in ally development, which is helpful for those working with sexual minorities (Jones, Brewster, & Jones, 2014). In relation to the LGBT community an ally is identified as a heterosexual individual who identifies as a member of a privileged group, actively works to understand the needs of LGBT individuals, and aligns with the social and political causes of the group (Jones, Brewster, & Jones, 2014; Rostosky, Black, Riggle, & Rosenkrantz, 2015).

When considered an ally for the LGBT community, one is expected to understand the typical daily experiences of individuals who are LGBT. Additionally, allies are expected to provide social supports, participate in support networks or programs, as well as display symbols that indicate general support of LGBT individuals (Jones, Brewster, & Jones, 2014; Meyer, 2003). The notion that counselors are called to become allies can have several implications based on the individual counselor's role in the field. According to Rees-Turyn (2007) professional activism can take shape in several ways; activism can range from a broad stance such as conducting research and reporting on the findings, or more narrowly as empowering clients to self-advocate. Activism related to the specific needs of the LGBT population is one way that the

counseling field can combat social stigma that sexual minorities face and better familiarize future counselors with the concerns LGBT clients experience.

Implications for Counselor Educators

While the research in circulation is rather thin regarding suggestions for improvement in relation to increasing multicultural counseling competency in counselor education programs, it is growing. Troutman and Packer-Williams (2014) suggested that counselor educators intentionally include the LGBT population, encourage affirmative language, explore heterosexual privilege, explicitly state the program's position on training culturally competent counselors, and integrate LGBT training into the curriculum. Incorporating the aforementioned material into the classroom setting will aid in preparing future counselors to effectively work with LGBT individuals. Outside of the classroom it is suggested that universities collaborate with local LGBT organizations, engage in multicultural skills trainings, highlight that identities are complex and fluid, become and ally, and advocate for more specificity in regard to CACREP standards (Troutman & Packer-Williams, 2014). By working to embrace and incorporate the suggestions offered by Troutman and Packer-Williams it is the hope that there will be more inclusion of the LGBT population, and LGBT related issues within the classroom. Creating an environment that is LGBT aware will aid in training culturally competent counselors who can effectively work with multiculturally diverse clients.

Making small but noticeable efforts to incorporate LGBT training techniques into all counseling courses could lead to counselors in training feeling more competent to work with LGBT individuals upon graduation. While changes to counselor education curriculum could foster an environment where emphasis is placed upon competency in relation to counseling

multicultural individuals, there are also other ways to foster competency. Pack-Brown, Thomas, and Seymour (2008) encouraged an ethics-based approach to educate future counselors and prepare them to work with individuals from all walks of life.

Sharing the importance of ethical practice, especially as it relates to personal values and world views, with counselors in training may prove to be essential in developing culturally competent counselors (Sells & Hagedorn, 2015; Seymour, 2008; Smith & Okech, 2016). Due to recent court cases, such as House Bill 1840 in Tennessee, there has been much discussion about the appropriateness of referring out a client based on the personal values of counselors. The passing of House Bill 1840 directly impacts the field of counseling as well as counselor education because it allows for individuals to be refused services based on the counselor's personal values; in doing so we are not only in direct violation of the ACA code of ethics but doing a disservice to our client. As counselor educators it is important to express that future counselors need to put aside personal values in order to comply with ethical standards of the profession; this can be done through class discussions and relevant case studies.

References

American Counseling Association. (2014). ACA Code of Ethics. Alexandria, VA: Author.

Asta, E. L., & Vacha-Haase, T. (2013). Heterosexual ally development in counseling psychologists: Experiences, training, and advocacy. *The Counseling Psychologist*, *41*(4), 493-529. doi:10.1177/0011000012453174

Biaggio, M., Orchard, S., Larson, J., Petrino, K., & Mihara, R. (2003). Guidelines for gay/lesbian/bisexual-affirmative educational practices in graduate psychology programs. *Professional Psychology: Research and Practice*, 34(5), 548-554. doi:10.1037/0735-7028.34.5.548

Bidell, M. P. (2013). Addressing disparities: The impact of a lesbian, gay, bisexual, and transgender graduate counselling course. *Counselling & Psychotherapy Research*, *13*(4), 300-307. doi:10.1080/14733145.2012.741139

Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *American Journal of Orthopsychiatry*, *84*(1), 35-45. doi:10.1037/h0098851

Brewster, M. E., Moradi, B., DeBlaere, C., & Velez, B. L. (2013). Navigating the borderlands: The roles of minority stressors, bicultural self-efficacy, and cognitive flexibility in the mental health of bisexual individuals. *Journal of Counseling Psychology*, *60*(4), 543-556. doi:10.1037/a0033224

Chang, C. Y., Crethar, H. C., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision. *Counselor Education and Supervision*, *50*(2), 82-87. doi:10.1002/j.1556-6978.2010.tb00110.x

Chang, C. Y., Minton, C. B., Dixon, A. L., Myers, J. E., & Sweeney, T. J. (2012). Professional

    counseling excellence through leadership and advocacy. New York, NY:

    Routledge/Taylor & Francis Group.

D'Andrea, M., & Heckman, E. F. (2008). Contributing to the ongoing evolution of the

    multicultural counseling movement: An introduction to the special issue. *Journal of*

    Counseling & Development, *86*(3), 259-268. doi:10.1002/j.1556-6678.2008.tb00507.x

Eliason, M. J., & Hughes, T. (2004). Treatment counselor's attitudes about lesbian, gay,

    bisexual, and transgendered clients: Urban vs. rural settings. *Substance Use & Misuse*,

    39(4), 625-644. doi:10.1081/JA-120030063

Graham, S. R., Carney, J. S., & Kluck, A. S. (2012). Perceived competency in working with

    LGB clients: Where are we now? *Counselor Education and Supervision*, *51*(1), 2-16.

    doi:10.1002/j.1556-6978.2012.00001.x

Helms, J. E., Nicolas, G., & Green, C. E. (2010). Racism and ethnoviolence as trauma:

    Enhancing professional training. *Traumatology, 16(4),* 53-62. doi:

    10.1177/1534765610389595

Ida, D.J. (2007). Cultural competency and recovery within diverse populations. *Psychiatric*

    Rehabilitation Journal, 31(1), 49-53. Doi:102975/31.1.2007.29.53

Jones, K. N., Brewster, M. E., & Jones, J. A. (2014). The creation and validation of the LGBT

    Ally Identity Measure. *Psychology of Sexual Orientation And Gender Diversity*, *1*(2),

    181-195. doi:10.1037/sgd0000033

Kağnici, D. Y. (2014). Reflections of a multicultural counseling course: A qualitative study with

    counseling students and counselors. *Kuram Ve Uygulamada Eğitim Bilimleri, 14(1),* 53-

    62.

King, M., Semlyen, J., Tai, S.S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry, 8*, 70–78.

Lee, C. C. (Ed.). (2007a). *Counseling for social justice.* Alexandria, VA: American Counseling Association.

Logan, C. R., & Barret, R. (2006). Counseling competencies for sexual minority clients. Journal of LGBT Issues in Counseling, 1(1), 3-22. doi: 10.1300/J462v01n01_02

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, *129*(5), 674-697. doi:10.1037/0033-2909.129.5.674

Murphy, J.A., Rawlings, E.I., & Howe, S.R. (2002). A survey of clinical psychologists on treating lesbian, gay, and bisexual clients. *Professional Psychology: Research and Practice, 33*, 183-189

Nadal, K. L. (2008). Preventing racial, ethnic, gender, sexual minority, disability, and religious microaggressions: Recommendations for promoting positive mental health. Prevention in Counseling Psychology: Theory, Research, Practice and Training, 2, 22-27.

Noga-Styron, K. E., Reasons, C. E., & Peacock, D. (2012). The last acceptable prejudice: An overview of LGBT social and criminal injustice issues within the USA. *Contemporary Justice Review*, *15*(4), 369-398. doi:10.1080/10282580.2012.734564

Pack-Brown, S. P., Thomas, T. L., & Seymour, J. M. (2008). Infusing professional ethics in to counselor education programs: A multicultural/social justice perspective. *Journal of Counseling & Development*, *86*(3), 296-302. doi:10.1002/j.1556-6678.2008.tb00512.x

Rock, M., Carlson, T.S., & McGeorge, C.R. (2010). Does affirmative training matter? Assessing

    CFT students' beliefs about sexual orientation and their level of affirmative training.

    Journal of Marital & Family Therapy, 36, 171184. doi: 10.1111/j.1752-

    0606.2009.00172.x

Rostosky, S. S., Black, W. W., Riggle, E. B., & Rosenkrantz, D. (2015). Positive aspects of

    being a heterosexual ally to lesbian, gay, bisexual and transgender (LGBT)

    people. *American Journal Of Orthopsychiatry*, *85*(4), 331-338. doi:10.1037/ort0000056

Sells, J. N., & Hagedorn, W. B. (2016). CACREP accreditation, ethics, and the affirmation of

    both religious and sexual identities: A response to Smith and Okech. *Journal of*

    Counseling & Development, *94*(3), 265-279. doi:10.1002/jcad.12083

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The

    experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of*

    Counseling Psychology, 58(2), 210-221. doi: 10.1037/a0022251

Smith, L. C., & Okech, J. A. (2016). Ethical issues raised by CACREP accreditation of programs

    within institutions that disaffirm or disallow diverse sexual orientations. *Journal of*

    Counseling & Development, *94*(3), 252-264. doi:10.1002/jcad.12082

Troutman, O., & Packer-Williams, C. (2014). Moving Beyond CACREP standards: Training

    counselors to work competently with LGBT clients. *The Journal of Counselor*

    Preparation and Supervision. 6(1).

Watson, Z. P., Herlihy, B. R., & Pierce, L. A. (2006). Forging the link between multicultural

    competence and ethical counseling practice: A historical perspective. *Counseling and*

    Values, 50(2), 99-107. doi:10.1002/j.2161-007X.2006.tb00046.x

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